PREMERA | BLUE CROSS

Non-Individual Plans Only

View Individual Plan code list.

Code List

(CODES REVIEWED ARE SUBJECT TO CHANGE)

We're currently working with local government regarding the COVID-19 virus and its impact on our area.
View COVID-19 FAQ.

How do I ensure accurate coverage information?

Sign into Availity, consult the member benefit booklet, or contact a customer service representative to determine coverage for a specific medical service or supply. Specific codes can be found within the Code List on the following pages. View list of codes.

What is the Code list?

This is a listing of the codes found in the Company's medical policies. The Code list provides the following information:

- The code and type of code (CPT or HCPCS) with a description
- The type of review required (e.g., pre-service, prior authorization, or retrospective review) or if the service potentially may be denied
- If the code must meet medical necessity criteria to be approved, or if it is considered investigative, cosmetic, specialized durable medical equipment, or is an unlisted (non-specific) code
- If specific medical records are required with the request

What are the types of review done before a service is provided?

There are two types of review conducted prior to a service being provided: prior authorization and a pre-service review. Each type of review determines if the service is medically necessary before the member's admission, stay, other service, or course of treatment, including outpatient procedures and services. Services that are not medically necessary are not covered, whether the review is done as a prior authorization or pre-service.

- Prior authorization: Prior authorization/certification is *required* by the member's contract. If a provider performs a service or procedure without prior authorization medical necessity review, depending on the member's benefit plan, the charges/claim will either be denied, or a penalty will be applied.
- Pre-service review: This is a utilization management review. Pre-service reviews are not contractually required; however, if a pre-service review for medical necessity is not obtained, we will conduct a retrospective medical necessity review. If a provider performs a service or procedure without pre-service review, the member or provider may have to pay the full-service cost.

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What is post service or retrospective review?
This refers to any review conducted after services have been provided, including outpatient procedures and services.

Services requiring prior authorization are listed below.
This list is subject to change. Please refer to the member's contract for specific coverage details.

Behavioral Health
- Inpatient admission (mental health and substance abuse disorder)
- Partial hospitalization programs (mental health and substance abuse disorder)
- Residential treatment programs (mental health and substance abuse disorder)

Dental Services
- Anesthesia for dental services and related facility charges
- Medically necessary orthodontia (medically necessary braces for the teeth)
- Orthognathic surgery (jaw enlargement or reduction)
- Pediatric orthodontia, non-routine (non-routine braces for children)
- Sleep apnea intraoral appliances (devices worn in the mouth to treat sleep apnea)
- Temporomandibular (TMJ) treatments (MRIs, oral splints, mouth guards, TMJ surgery)

Durable Medical Equipment (DME) and Prosthetic Devices
DME **rental** for home use does not require prior authorization. However, rental beyond 3 months may be reviewed for ongoing medical necessity.

Prior authorization may be required for **purchase** of DME items including but not limited to:
- Bone growth stimulators – electronic and ultrasonic
- Chest compression vests and devices
- Cochlear devices
- Custom-made knee braces
- Electrical stimulation devices – includes bone growth stimulators
- Electronic, mechanical or microprocessor-controlled artificial limb or joint
- Equipment and supplies to treat obstructive sleep apnea: CPAP, BiPAP and APAP machines and related supplies
- Hospital beds and accessories
    - No prior authorization needed for rental of standard beds for hospital to home transitions for less than 3 months

- Lymphedema pumps (pumps to reduce swelling)
- Medical foods
- Myoelectric upper limb prosthetic (externally powered artificial arm or hand)
- Oral devices, appliances, surgical splints and impressions – includes preparation
- Power-operated lifting devices
- Standing frames
- Vagal nerve stimulators other than TENS (implanted devices to stimulate a specific nerve)
- Wheelchairs, power-operated vehicles, and scooters
  - No prior authorization is needed for standard manual wheelchairs rented for less than 3 months

Home Health Care

- Home health
- Pain management/palliative care (some procedures)
- Skilled home health care services
- Skilled hourly nursing care

Inpatient Facility Admissions

- Admission to a skilled nursing facility, a long-term acute care hospital (LTACH) or a rehabilitation facility
- Admission to all residential treatment programs
- All planned (elective) inpatient hospital care (surgical, non-surgical, behavioral health and/or substance abuse)
  - Elective admissions must have prior authorization **before** admission
  - **For facilities only**, if the service for which the member is admitted is not included in the list below, notification from the facility is required within 24 hours of the admission

Medications

The following list of drugs requires prior authorization and review for medical necessity if covered through the member's medical benefit. Drugs requiring prior-authorization paid through a member's medical benefit may be added at any time to medical policies.

- Adrenal hormones
- Adrenergics
- Androgens
- Angiotensin II receptor blockers & renin inhibitor
- Anorexiants
- Antiandrogens
- Anticholinergics and antispasmodics

- Anticonvulsants
- Antidiarrheals
- Antiestrogens
- Antimalarials
- Antimetabolites
- Antiparkinsonism agents
- Antiplatelet drugs
- Antipsoriatic/Antiseborrheic
- Antivertigo and antiemetic agents
- Beta agonists inhalers
- Beta blockers
- Blood derivatives
- Blood glucose monitoring devices & supplies
- Botulinum toxins
- Bowel evacuants
- Combination narcotic/analgesics
- Compounds
- Direct acting miotics
- Drugs with significant changes in product labeling
- Erythroid stimulants
- Estrogen combinations
- Estrogens
- Fluoroquinolones
- Gene therapies and cellular immunotherapies such as CAR-T
- Glucose elevating agents
- Gonadotropin & related agents
- Gout therapy
- Growth hormones (excluding idiopathic short stature without growth hormone deficiency)
- Headache therapy
- Hemostatics
- HIV/AIDS therapy
- Hypnotic agents
- Immunosuppressant drugs

- Inhaled corticosteroids
- Insulin therapy
- Interferons
- Interleukins
- Intranasal steroids
- Keratolytics
- Kits
- Lipid/Cholesterol lowering agents
- Long acting nitrates
- MAO Inhibitors
- Miscellaneous agents
- Miscellaneous analgesics
- Miscellaneous antidepressants
- Miscellaneous antineoplastic drugs
- Miscellaneous Antiinfectives
- Miscellaneous Antineoplastic drugs
- Miscellaneous Antipsychotics
- Miscellaneous antivirals
- Miscellaneous cardiovascular agents
- Miscellaneous coagulation agents
- Miscellaneous dermatologicals
- Miscellaneous gastrointestinal agents
- Miscellaneous neurological therapy drugs
- Miscellaneous ophthalmologics
- Miscellaneous psychotherapeutic agents
- Miscellaneous pulmonary agents
- Miscellaneous rheumatological agents
- Miscellaneous urologicals
- Muscle relaxants and antispasmodic agents
- Myasthenia gravis
- Myeloid stimulants
- Narcotic antagonists
- Narcotics

- Newly FDA-approved drugs
- Non-insulin hypoglycemic agents
- NSAIDS
- NSAIDS-specific Cox II inhibitors
- Ovulatory stimulants
- Osteoporosis therapy
- Other glaucoma drugs
- Proton pump inhibitors
- Radiopharmaceuticals
- Selective serotonin reuptake inhibitors
- Smoking deterrents
- Specialty drugs
- Steroids
- Tetracyclines
- Therapy for acne
- Thiazide and related diuretics
- Topical anesthetics
- Topical antibacterials
- Topical antifungals
- Topical corticosteroids
- Vasodilators
- Vaccines & miscellaneous immunologicals
  - Immune globulins
  - Oral allergen therapy
- Vitamins & hematinics

Other services

- Elective (non-emergent) air transport
- Elective (non-emergent) ambulance transport
- Experimental and investigational services
- Therapy (physical/occupational/speech) after 1st 6 visits

Out-of-Network Services

If a provider is out-of-network and wants an in-network rate, the service will always require prior authorization.

Outpatient Imaging Tests

- Contrast enhanced computed tomography (CT) angiography of the heart
- Computed tomography (CT) scans
- Echocardiograms (ultrasound test of the heart)
- Magnetic resonance imaging (MRI) and magnetic resonance angiography (MRA)
- Magnetic resonance spectroscopy (special imaging to look at the brain)
- Nuclear cardiology (using special dyes to look at heart function)
- Positron emission tomography (PET and PET/CT)

Pediatric Orthodontia (non-routine): These services are reviewed by dental review staff. Requests should be faxed to 425-918-5956. View the dental pre-service request form.

Surgical, Medical, Therapeutic, Diagnostic and Reconstructive Procedures (inpatient or outpatient)

- Ablation therapy (destruction of abnormal tissue)
- Artificial intervertebral disc, any level (artificial disc between vertebrae in the spine)
- Bioengineered skin substitutes
- Blepharoplasty (eyelid surgery)
- Bone-anchored and implantable hearing aids
- Breast surgeries – selected: implant removal, mastectomy for gynecomastia (removal of breast tissue in males), prophylactic mastectomy (removal of breasts to prevent breast cancer), reduction mammoplasty (breast reduction)
- Cardiac devices, including related services for implantation if applicable: ventricular assist devices for outpatient (a certain kind of device to help the heart pump), implanted and wearable defibrillators (a device to shock the heart into a normal rhythm); closure devices for septal defects (a hole in a specific part of the heart); transcatheter aortic valve replacement known as TAVR/TAVI (a specific procedure that replaces the heart's aortic valve)
- Certain injections for pain management, including but not limited to therapeutic agents and anesthesia
- Chelation therapy
- Chemotherapy administration and radiation oncology
- Cochlear implantation (stimulates the nerve in the inner ear)
- Corneal remodeling/keratoprosthesis (reshaping the clear front layer of the eyeball/implanting an artificial cornea)
- Cosmetic or reconstructive surgery usually done to change the appearance (such as face lifts, brow lifts, cervicoplasty, collagen implants, chemical peels/abrasions, abdominoplasty [tummy tuck], liposuction, body contouring surgery [skin fold or fat removal from torso or extremity], nose or ear remodeling, scar revision, bioengineered skin, and others)

- Cryosurgical ablation/ablation of tumors (using extreme cold to destroy tumors)
- Deep brain stimulation (electrical stimulation of the brain through implanted wires)
- Electrophysiological studies
- Esophageal sphincter procedures (anti-reflux surgery)
- Extracorporeal photopheresis (collecting cells, treating them with special light, and then returning specific cells to the body)
- Facet arthroplasty (replacing a specific part of a joint in the spine with an artificial support)
- Facility-based polysomnography (sleep studies done in a lab)
- Foot surgery (some specified surgeries)
- Gastric restrictive procedures (weight loss surgery that makes the stomach smaller)
- Genetic testing and analysis
- Hernia repair
- Hyaluronan or derivative for intra-articular injection
- Hyperbaric oxygen therapy (pressurized oxygen to treat certain kinds of wounds and illnesses)
- Hysterectomy
- Implantation or application of electric stimulator devices – selected: gastric (stomach), spinal cord, sacral nerve (a specific nerve that affects bladder and bowel function), pelvic floor (muscles at the bottom of the pelvis), implanted bone stimulators, posterior tibial nerve (a nerve running down the back of the lower leg)
- Intensive outpatient hospitalization
- Interspinous distraction devices (spacers between the bones of the spine)
- Interoperative neurophysiology monitoring, continuous
- Joint surgeries, arthroscopy: ankle, elbow, foot, and wrist
- Lab services
- Major joint surgeries, arthroplasty/arthroscopy: knee, hip, and shoulder
- Mitral valve repair (repair of a specific heart valve)
- Myringotomy
- Nasal/sinus surgery
- Panniculectomy (removing an apron of fat and tissue that hangs far below the waist)
- Radiation therapy – selected: stereotactic radiosurgery, gamma knife, proton beam, intensity modulated radiation therapy (IMRT), high-dose rate electronic brachytherapy, brachytherapy
- Radiofrequency: ablation of tumors and treatment of facet joints (using heat to destroy tumors and treat nerves at specific joints of the spine)
- Septoplasty
- Spine surgeries and treatments
- Surgeries related to gender reassignment

- Surgery to treat sleep apnea
- Surgical treatments for the temporomandibular joint (joint that connects the jaw to the rest of the skull)
- Therapeutic apheresis (removing certain components of the blood)
- Total ankle replacement
- Transcatheter occlusion or embolization for tumor destruction (closing off the blood supply to tumors)
- Transcranial magnetic stimulation, TMS (magnetic pulses to the brain)
- Tympanoplasty without mastoidectomy (including canalplasty, atticotomy and/or middle ear surgery)
- Upper gastrointestinal endoscopy (a viewing scope inserted through the mouth to examine the esophagus, stomach, and first part of the small intestine)
- Vascular embolization or occlusion for tumors, organ ischemia or infarction (closing off a blood vessel to treat a tumor or other tissue)
- Vagus nerve blocking therapy (obesity treatment that blocks signals going to the nerve that goes to the stomach)
- Varicose veins and perforator veins – all procedures
- Vascular surgery
- Vertebroplasty, kyphoplasty, or sacroplasty (specific treatments for stabilizing compression fractures in the spine)

Transplants (inpatient or outpatient)

- Autologous progenitor cell therapy (stem cell transplants)
- Complex organ transplants (small bowel, lung, heart, liver, multi-organ, face, limb)
  - We recommend notifying the plan of scheduled kidney, liver, heart, or multi-organ transplant to ensure the highest level of coverage
- Transplant donor procedures and services (for all types of transplants)

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Please note that any planned inpatient stay always requires prior authorization (PA) except maternity-related services.
Items with PA require review and approval before the service is performed.

Code List

To check the status of a code against a member's plan, use Availity, then submit the review and check the status of the review online. This list is not exhaustive. The presence of codes on this list does not necessarily indicate coverage under the member benefits contract. Member contracts differ in their benefits. Always use Availity, consult the member benefit booklet, or contact a customer service representative to determine coverage for a specific medical service or supply.

Code	Description	Plan Review Requirement	Reviewed For	Records Request
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 Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
0002U	Oncology (colorectal), quantitative assessment of three urine metabolites (ascorbic acid, succinic acid and carnitine) by liquid chromatography with tandem mass spectrometry (LC-MS/MS) using multiple reaction monitoring acquisition, algorithm reported as likelihood of adenomatous polyps	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0003U	Oncology (ovarian) biochemical assays of five proteins (apolipoprotein A-1, CA 125 II, follicle stimulating hormone, human epididymis protein 4, transferrin), utilizing serum, algorithm reported as a likelihood score	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0004M	Scoliosis, DNA analysis of 53 single nucleotide polymorphisms (SNPs), using saliva, prognostic algorithm reported as a risk score	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
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 Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. WA PLAN MEMBERS ONLY: No prior authorization required for requests related to stage 3 or 4 cancer; or remittent, recurrent, relapsed, or metastatic cancers. Post-service review may be required through Carelon.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
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 Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. WA PLAN MEMBERS ONLY: No prior authorization required for requests related to stage 3 or 4 cancer; or remittent, recurrent, relapsed, or metastatic cancers. Post-service review may be required through Carelon.
0007M	Oncology (gastrointestinal neuroendocrine tumors), real-time PCR expression analysis of 51 genes, utilizing whole peripheral blood, algorithm reported as a nomogram of tumor disease index	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. WA PLAN MEMBERS ONLY: No prior authorization required for requests related to stage 3 or 4 cancer; or remittent, recurrent, relapsed, or metastatic cancers. Post-service review may be required through Carelon.
0011M	Oncology, prostate cancer, mRNA expression assay of 12 genes (10 content and 2 housekeeping), RT-PCR test utilizing blood plasma and/or urine, algorithms to predict high-grade prostate cancer risk	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. WA PLAN MEMBERS ONLY: No prior authorization required for requests related to stage 3 or 4 cancer; or remittent, recurrent, relapsed, or metastatic cancers. Post-service review may be required through Carelon.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
0012M	Oncology (urothelial), mRNA, gene expression profiling by real-time quantitative PCR of five genes (MDK, HOXA13, CDC2 [CDK1], IGFBP5, and XCR2), utilizing urine, algorithm reported as a risk score for having urothelial carcinoma	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. WA PLAN MEMBERS ONLY: No prior authorization required for requests related to stage 3 or 4 cancer; or remittent, recurrent, relapsed, or metastatic cancers. Post-service review may be required through Carelon.
0013M	Oncology (urothelial), mRNA, gene expression profiling by real-time quantitative PCR of five genes (MDK, HOXA13, CDC2 [CDK1], IGFBP5, and CXCR2), utilizing urine, algorithm reported as a risk score for having recurrent urothelial carcinoma	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. WA PLAN MEMBERS ONLY: No prior authorization required for requests related to stage 3 or 4 cancer; or remittent, recurrent, relapsed, or metastatic cancers. Post-service review may be required through Carelon.
0015M	Adrenal cortical tumor, biochemical assay of 25 steroid markers, utilizing 24-hour urine specimen and clinical parameters, prognostic algorithm reported as a clinical risk and integrated clinical steroid risk for adrenal cortical carcinoma, adenoma or other adrenal malignancy	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
0016M	Oncology (bladder), mRNA, microarray gene expression profiling of 209 genes, utilizing formalin-fixed paraffin-embedded tissue, algorithm reported as molecular subtype (luminal, luminal infiltrated, basal, basal claudin-low, neuroendocrine-like)	Possible Denial; Medical Records Optional	Investigative	Documentation optional.

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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 Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. WA PLAN MEMBERS ONLY: No prior authorization required for requests related to stage 3 or 4 cancer; or remittent, recurrent, relapsed, or metastatic cancers. Post-service review may be required through Carelon.
0017M	Oncology (diffuse large B-cell lymphoma [DLBCL]), mRNA, gene expression profiling by fluorescent probe hybridization of 20 genes, formalin-fixed paraffin-embedded tissue, algorithm reported as cell of origin	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. WA PLAN MEMBERS ONLY: No prior authorization required for requests related to stage 3 or 4 cancer; or remittent, recurrent, relapsed, or metastatic cancers. Post-service review may be required through Carelon.
0017U	Oncology (hematolymphoid neoplasia), JAK2 mutation, DNA, PCR amplification of exons 12-14 and sequence analysis, blood or bone marrow, report of JAK2 mutation not detected or detected	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. WA PLAN MEMBERS ONLY: No prior authorization required for requests related to stage 3 or 4 cancer; or remittent, recurrent, relapsed, or metastatic cancers. Post-service review may be required through Carelon.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
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 Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. WA PLAN MEMBERS ONLY: No prior authorization required for requests related to stage 3 or 4 cancer; or remittent, recurrent, relapsed, or metastatic cancers. Post-service review may be required through Carelon.
0019M	Cardiovascular disease, plasma, analysis of protein biomarkers by aptamer-based microarray & algorithm reported as 4-year likelihood of coronary event in high-risk populations.	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
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 Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. WA PLAN MEMBERS ONLY: No prior authorization required for requests related to stage 3 or 4 cancer; or remittent, recurrent, relapsed, or metastatic cancers. Post-service review may be required through Carelon.
0020M	Oncology (central nervous system), analysis of 30000 DNA methylation loci by methylation array, utilizing DNA extracted from tumor tissue, diagnostic algorithm reported as probability of matching a reference tumor subclass	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.

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0021U	Oncology (prostate), detection of 8 autoantibodies (ARF 6, NKX3-1, 5'-UTR-BMI1, CEP 164, 3'-UTR-Ropporin, Desmocollin, AURKAIP-1, CSNK2A2), multiplexed immunoassay and flow cytometry serum, algorithm reported as risk score	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
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 Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
0023U	Oncology (acute myelogenous leukemia), DNA, genotyping of internal tandem duplication, p.D835, p.I836, using mononuclear cells, reported as detection or nondetection of FLT3 mutation and indication for or against the use of midostaurin	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. WA PLAN MEMBERS ONLY: No prior authorization required for requests related to stage 3 or 4 cancer; or remittent, recurrent, relapsed, or metastatic cancers. Post-service review may be required through Carelon.
0026U	Oncology (thyroid), DNA and mRNA of 112 genes, next-generation sequencing, fine needle aspirate of thyroid nodule, algorithmic analysis reported as a categorical result ("Positive, high probability of malignancy" or "Negative, low probability of malignancy")	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. WA PLAN MEMBERS ONLY: No prior authorization required for requests related to stage 3 or 4 cancer; or remittent, recurrent, relapsed, or metastatic cancers. Post-service review may be required through Carelon.

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0027U	JAK2 (Janus kinase 2) (eg, myeloproliferative disorder) gene analysis, targeted sequence analysis exons 12-15	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. WA PLAN MEMBERS ONLY: No prior authorization required for requests related to stage 3 or 4 cancer; or remittent, recurrent, relapsed, or metastatic cancers. Post-service review may be required through Carelon.
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 Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
0030U	Drug metabolism (warfarin drug response), targeted sequence analysis (ie, CYP2C9, CYP4F2, VKORC1, rs12777823)	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
0031U	CYP1A2 (cytochrome P450 family 1, subfamily A, member 2)(eg, drug metabolism) gene analysis, common variants (ie, *1F, *1K, *6, *7)	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
0032U	COMT (catechol-O-methyltransferase)(drug metabolism) gene analysis, c.472G>A (rs4680) variant	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.

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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 Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
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 Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
0036U	Exome (ie, somatic mutations), paired formalin-fixed paraffin-embedded tumor tissue and normal specimen, sequence analyses	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. WA PLAN MEMBERS ONLY: No prior authorization required for requests related to stage 3 or 4 cancer; or remittent, recurrent, relapsed, or metastatic cancers. Post-service review may be required through Carelon.
0037U	Targeted genomic sequence analysis, solid organ neoplasm, DNA analysis of 324 genes, interrogation for sequence variants, gene copy number amplifications, gene rearrangements, microsatellite instability and tumor mutational burden	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. WA PLAN MEMBERS ONLY: No prior authorization required for requests related to stage 3 or 4 cancer; or remittent, recurrent, relapsed, or metastatic cancers. Post-service review may be required through Carelon.

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0038U	Vitamin D, 25 hydroxy D2 and D3, by LC-MS/MS, serum microsample, quantitative	Retrospective Review	Medical Necessity	Only covered for diagnoses that are considered medically necessary. Medical records optional. See medical policy 2.04.507
0040U	BCR/ABL1 (t(9;22)) (eg, chronic myelogenous leukemia) translocation analysis, major breakpoint, quantitative	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. WA PLAN MEMBERS ONLY: No prior authorization required for requests related to stage 3 or 4 cancer; or remittent, recurrent, relapsed, or metastatic cancers. Post-service review may be required through Carelon.
0042T	Cerebral perfusion analysis using computed tomography with contrast administration, including post-processing of parametric maps with determination of cerebral blood flow, cerebral blood volume, and mean transit time	Prior Authorization Required	Advanced Imaging	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
0045U	Oncology (breast ductal carcinoma in situ), mRNA, gene expression profiling by real-time RT-PCR of 12 genes (7 content and 5 housekeeping)	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. WA PLAN MEMBERS ONLY: No prior authorization required for requests related to stage 3 or 4 cancer; or remittent, recurrent, relapsed, or metastatic cancers. Post-service review may be required through Carelon.

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0046U	FLT3 (fms-related tyrosine kinase 3) (eg, acute myeloid leukemia) internal tandem duplication (ITD) variants, quantitative	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. WA PLAN MEMBERS ONLY: No prior authorization required for requests related to stage 3 or 4 cancer; or remittent, recurrent, relapsed, or metastatic cancers. Post-service review may be required through Carelon.
0047U	Oncology (prostate), mRNA, gene expression profiling by real-time RT-PCR of 17 genes (12 content and 5 housekeeping), utilizing formalin-fixed paraffin-embedded tissue, algorithm reported as a risk score	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. WA PLAN MEMBERS ONLY: No prior authorization required for requests related to stage 3 or 4 cancer; or remittent, recurrent, relapsed, or metastatic cancers. Post-service review may be required through Carelon.
0048U	Oncology (solid organ neoplasia), DNA, targeted sequencing of protein-coding exons of 468 cancer-associated genes, including interrogation for somatic mutations and microsatellite instability, matched with normal specimens	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. WA PLAN MEMBERS ONLY: No prior authorization required for requests related to stage 3 or 4 cancer; or remittent, recurrent, relapsed, or metastatic cancers. Post-service review may be required through Carelon.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
0049U	NPM1 (nucleophosmin) (eg, acute myeloid leukemia) gene analysis, quantitative	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. WA PLAN MEMBERS ONLY: No prior authorization required for requests related to stage 3 or 4 cancer; or remittent, recurrent, relapsed, or metastatic cancers. Post-service review may be required through Carelon.
0050U	Targeted genomic sequence analysis panel, acute myelogenous leukemia, DNA analysis, 194 genes, interrogation for sequence variants or rearrangements	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. WA PLAN MEMBERS ONLY: No prior authorization required for requests related to stage 3 or 4 cancer; or remittent, recurrent, relapsed, or metastatic cancers. Post-service review may be required through Carelon.
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 Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
0060U	Twin zygosity, genomic targeted sequence analysis of chromosome 2, using circulating cell-free DNA in maternal blood	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
0062U	Autoimmune (systemic lupus erythematosus), IgG and IgM analysis of 80 biomarkers, utilizing serum, algorithm reported with a risk score	Possible Denial; Medical Records Optional	Investigative	Documentation optional.

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0069U	Oncology (colorectal), microRNA, RT-PCR expression profiling of miR-31-3p, formalin-fixed paraffin-embedded tissue, algorithm reported as an expression score	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. WA PLAN MEMBERS ONLY: No prior authorization required for requests related to stage 3 or 4 cancer; or remittent, recurrent, relapsed, or metastatic cancers. Post-service review may be required through Carelon.
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 Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
0071T	Focused ultrasound ablation of uterine leiomyomata, including MR guidance; total leiomyomata, volume less than 200 cc of tissue	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
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 Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
0072T	Focused ultrasound ablation of uterine leiomyomata, including MR guidance; total leiomyomata volume greater or equal to 200 cc of tissue	Possible Denial; Medical Records Optional	Investigative	Documentation optional.

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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 Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
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 Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
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 Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
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 Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
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 Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.

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0079U	Comparative DNA analysis using multiple selected single-nucleotide polymorphisms (SNPs), urine and buccal DNA, for specimen identity verification	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
0080U	Oncology (lung), mass spectrometric analysis of galectin-3-binding protein and scavenger receptor cysteine-rich type 1 protein M130, with five clinical risk factors (age, smoking status, nodule diameter, nodule-spiculation status and nodule location), utilizing plasma, algorithm reported as a categorical probability of malignancy	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
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 Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
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 Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
0089U	Oncology (melanoma), gene expression profiling by RTqPCR, PRAME and LINC00518, superficial collection using adhesive patch(es)	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. WA PLAN MEMBERS ONLY: No prior authorization required for requests related to stage 3 or 4 cancer; or remittent, recurrent, relapsed, or metastatic cancers. Post-service review may be required through Carelon.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
0090U	Oncology (cutaneous melanoma), mRNA gene expression profiling by RT-PCR of 23 genes (14 content and 9 housekeeping), utilizing formalin-fixed paraffin-embedded tissue, algorithm reported as a categorical result (ie, benign, indeterminate, malignant)	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. WA PLAN MEMBERS ONLY: No prior authorization required for requests related to stage 3 or 4 cancer; or remittent, recurrent, relapsed, or metastatic cancers. Post-service review may be required through Carelon.
0092U	Oncology (lung), three protein biomarkers, immunoassay using magnetic nanosensor technology, plasma, algorithm reported as risk score for likelihood of malignancy	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0094U	Genome (eg, unexplained constitutional or heritable disorder or syndrome), rapid sequence analysis	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
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 Required	Medical necessity including site of service	Submit recent history and physical, plan of care, and documentation of medical necessity including for site of service.
0100T	Placement of a subconjunctival retinal prosthesis receiver and pulse generator, and implantation of intra-ocular retinal electrode array, with vitrectomy	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0101T	Extracorporeal shock wave involving musculoskeletal system, not otherwise specified; high energy	Possible Denial; Medical Records Optional	Investigative	Documentation optional.

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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 Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
0102T	Extracorporeal shock wave, high energy, performed by a physician, requiring anesthesia other than local, involving lateral humeral epicondyle	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
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 Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
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 Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
0108U	Gastroenterology (Barrett's esophagus), whole slide-digital imaging, including morphometric analysis, computer-assisted quantitative immunolabeling of 9 protein biomarkers (p16, AMACR, p53, CD68, COX-2, CD45RO, HIF1a, HER-2, K20) and morphology, formalin-fixed paraffin-embedded tissue, algorithm reported as risk of progression to high-grade dysplasia or cancer	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
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 Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. WA PLAN MEMBERS ONLY: No prior authorization required for requests related to stage 3 or 4 cancer; or remittent, recurrent, relapsed, or metastatic cancers. Post-service review may be required through Carelon.
0112U	Infectious agent detection and identification, targeted sequence analysis (16S and 18S rRNA genes) with drug-resistance gene	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
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 Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. WA PLAN MEMBERS ONLY: No prior authorization required for requests related to stage 3 or 4 cancer; or remittent, recurrent, relapsed, or metastatic cancers. Post-service review may be required through Carelon.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
0114U	Gastroenterology (Barrett's esophagus), VIM and CCNA1 methylation analysis, esophageal cells, algorithm reported as likelihood for Barrett's esophagus	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. WA PLAN MEMBERS ONLY: No prior authorization required for requests related to stage 3 or 4 cancer; or remittent, recurrent, relapsed, or metastatic cancers. Post-service review may be required through Carelon.
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 Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
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 Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. WA PLAN MEMBERS ONLY: No prior authorization required for requests related to stage 3 or 4 cancer; or remittent, recurrent, relapsed, or metastatic cancers. Post-service review may be required through Carelon.
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 Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.

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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 Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
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 Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
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 Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
0133U	Hereditary prostate cancer-related disorders, targeted mRNA sequence analysis panel (11 genes) (List separately in addition to code for primary procedure)	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.

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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 Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
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 Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
0136U	ATM (ataxia telangiectasia mutated) (eg, ataxia telangiectasia) mRNA sequence analysis (List separately in addition to code for primary procedure)	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
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 Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
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 Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
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 Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. WA PLAN MEMBERS ONLY: No prior authorization required for requests related to stage 3 or 4 cancer; or remittent, recurrent, relapsed, or metastatic cancers. Post-service review may be required through Carelon.
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 (FFPE) urothelial cancer tumor tissue, reported as FGFR gene alteration status	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. WA PLAN MEMBERS ONLY: No prior authorization required for requests related to stage 3 or 4 cancer; or remittent, recurrent, relapsed, or metastatic cancers. Post-service review may be required through Carelon.
0155U	Oncology (breast cancer) DNA, PIK3CA (PHOSPHATIDYLINOSITOL-4,5BISPHOSPHATE 3-KINASE, catalytic SUBUNIT ALPHA) 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 (FFPE) breast tumor tissue, reported as PIK3CA gene mutation status	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. WA PLAN MEMBERS ONLY: No prior authorization required for requests related to stage 3 or 4 cancer; or remittent, recurrent, relapsed, or metastatic cancers. Post-service review may be required through Carelon.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
0156U	Copy number (EG, intellectual disability, dysmorphology), sequence analysis	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
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 Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. WA PLAN MEMBERS ONLY: No prior authorization required for requests related to stage 3 or 4 cancer; or remittent, recurrent, relapsed, or metastatic cancers. Post-service review may be required through Carelon.
0158U	MLH1 (MUTL HOMOLOG 1) (EG, hereditary non-polyposis colorectal cancer, lynch syndrome) mrna sequence analysis (list separately in addition to code for primary procedure)	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
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 Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. WA PLAN MEMBERS ONLY: No prior authorization required for requests related to stage 3 or 4 cancer; or remittent, recurrent, relapsed, or metastatic cancers. Post-service review may be required through Carelon.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
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 Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. WA PLAN MEMBERS ONLY: No prior authorization required for requests related to stage 3 or 4 cancer; or remittent, recurrent, relapsed, or metastatic cancers. Post-service review may be required through Carelon.
0161U	PMS2 (PMS1 HOMOLOG 2, mismatch repair system component) (eg, hereditary nonpolyposis colorectal cancer, lynch syndrome) MRNA sequence analysis (list separately in addition to code for primary procedure)	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. WA PLAN MEMBERS ONLY: No prior authorization required for requests related to stage 3 or 4 cancer; or remittent, recurrent, relapsed, or metastatic cancers. Post-service review may be required through Carelon.
0162U	Hereditary colon cancer (lynch syndrome), targeted MRNA sequence analysis panel (MLH1, MSH2, MSH6, PMS2) (list separately in addition to code for primary procedure)	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. WA PLAN MEMBERS ONLY: No prior authorization required for requests related to stage 3 or 4 cancer; or remittent, recurrent, relapsed, or metastatic cancers. Post-service review may be required through Carelon.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
0163U	Oncology (colorectal) screening, biochemical enzyme-linked immunosorbent assay (ELISA) of 3 plasma or serum proteins (teratocarcinoma derived growth factor-1 [TDGF-1, Cripto-1], carcinoembryonic antigen [CEA], extracellular matrix protein [ECM]), with demographic data (age, gender, CRC-screening compliance) using a proprietary algorithm and reported as likelihood of CRC or advanced adenomas	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0164T	Removal of total disc arthroplasty, anterior approach, lumbar, each additional interspace (List separately in addition to code for primary procedure	Prior Authorization Required	Investigative	Submit history and physical, documentation of medical necessity and procedure report.
0165T	Revision of total disc arthroplasty (artificial disc),, anterior approach, lumbar, each additional interspace	Prior Authorization Required	Investigative	Submit history and physical, documentation of medical necessity and procedure report.
0169U	NUDT15 (nudix hydrolase 15) and TPMT (thiopurine S-methyltransferase) (eg, drug metabolism) gene analysis, common variants	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
0170U	Neurology (autism spectrum disorder [ASD]), RNA, next-generation sequencing, saliva, algorithmic analysis, and results reported as predictive probability of ASD diagnosis	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
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 Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. WA PLAN MEMBERS ONLY: No prior authorization required for requests related to stage 3 or 4 cancer; or remittent, recurrent, relapsed, or metastatic cancers. Post-service review may be required through Carelon.
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 Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. WA PLAN MEMBERS ONLY: No prior authorization required for requests related to stage 3 or 4 cancer; or remittent, recurrent, relapsed, or metastatic cancers. Post-service review may be required through Carelon.
0173U	Psychiatry (ie, depression, anxiety), genomic analysis panel, includes variant analysis of 14 genes	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
0174U	Oncology (solid tumor), mass spectrometric 30 protein targets, formalin-fixed paraffin-embedded tissue, prognostic and predictive algorithm reported as likely, unlikely, or uncertain benefit of 39 chemotherapy and targeted therapeutic oncology agents	Possible Denial; Medical Records Optional	Investigative	Documentation optional.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
0175U	Psychiatry (eg, depression, anxiety), genomic analysis panel, variant analysis of 15 genes	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
0176U	Cytolethal distending toxin B (CdtB) and vinculin IgG antibodies by immunoassay (ie, ELISA)	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
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 Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. WA PLAN MEMBERS ONLY: No prior authorization required for requests related to stage 3 or 4 cancer; or remittent, recurrent, relapsed, or metastatic cancers. Post-service review may be required through Carelon.
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 Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. WA PLAN MEMBERS ONLY: No prior authorization required for requests related to stage 3 or 4 cancer; or remittent, recurrent, relapsed, or metastatic cancers. Post-service review may be required through Carelon.
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	Possible Denial; Medical Records Optional	Investigative	Documentation optional.

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0181U	Red cell antigen (Colton blood group) genotyping (CO), gene analysis, AQP1 (aquaporin 1 [Colton blood group]) exon 1	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0182U	Red cell antigen (Cromer blood group) genotyping (CROM), gene analysis, CD55 (CD55 molecule [Cromer blood group]) exons 1-10	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0183U	Red cell antigen (Diego blood group) genotyping (DI), gene analysis, SLC4A1 (solute carrier family 4 member 1 [Diego blood group]) exon 19	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0184U	Red cell antigen (Dombrock blood group) genotyping (DO), gene analysis, ART4 (ADP-ribosyltransferase 4 [Dombrock blood group]) exon 2	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0185U	Red cell antigen (H blood group) genotyping (FUT1), gene analysis, FUT1 (fucosyltransferase 1 [H blood group]) exon 4	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0186U	Red cell antigen (H blood group) genotyping (FUT2), gene analysis, FUT2 (fucosyltransferase 2) exon 2	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0187U	Red cell antigen (Duffy blood group) genotyping (FY), gene analysis, ACKR1 (atypical chemokine receptor 1 [Duffy blood group]) exons 1-2	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0188U	Red cell antigen (Gerbich blood group) genotyping (GE), gene analysis, GYPC (glycophorin C [Gerbich blood group]) exons 1-4	Possible Denial; Medical Records Optional	Investigative	Documentation optional.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
0189U	Red cell antigen (MNS blood group) genotyping (GYPA), gene analysis, GYPA (glycophorin A [MNS blood group]) introns 1, 5, exon 2	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0190U	Red cell antigen (MNS blood group) genotyping (GYPB), gene analysis, GYPB (glycophorin B [MNS blood group]) introns 1, 5, pseudoexon 3	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0191U	Red cell antigen (Indian blood group) genotyping (IN), gene analysis, CD44 (CD44 molecule [Indian blood group]) exons 2, 3, 6	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
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	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
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	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0194U	Red cell antigen (Kell blood group) genotyping (KEL), gene analysis, KEL (Kell metallo-endopeptidase [Kell blood group]) exon 8	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0195U	KLF1 (Kruppel-like factor 1), targeted sequencing (ie, exon 13)	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0196U	Red cell antigen (Lutheran blood group) genotyping (LU), gene analysis, BCAM (basal cell adhesion molecule [Lutheran blood group]) exon 3	Possible Denial; Medical Records Optional	Investigative	Documentation optional.

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0197U	Red cell antigen (Landsteiner-Wiener blood group) genotyping (LW), gene analysis, ICAM4 (intercellular adhesion molecule 4 [Landsteiner-Wiener blood group]) exon 1	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
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	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
01999	Unlisted anesthesia procedure(s)	Medical necessity review will be performed upon claims submission with supporting documentation.	Medical Necessity	Review required at claims submission; submit description of procedure with supporting documentation (including operative report if surgical) only for the date of service performed.
0199U	Red cell antigen (Scianna blood group) genotyping (SC), gene analysis, ERMAP (erythroblast membrane associated protein [Scianna blood group]) exons 4, 12	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0200T	Percutaneous sacral augmentation (sacroplasty), unilateral injection(s), including the use of a balloon or mechanical device, when used, 1 or more needles	Prior Authorization Required	Investigative	Submit history and physical, documentation of medical necessity and procedure report.
0200U	Red cell antigen (Kx blood group) genotyping (XK), gene analysis, XK (X-linked Kx blood group) exons 1-3	Possible Denial; Medical Records Optional	Investigative	Documentation optional.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
0201T	Percutaneous sacral augmentation (sacroplasty), bilateral injections, including the use of a balloon or mechanical device, when used, 2 or more needles	Prior Authorization Required	Investigative	Submit history and physical, documentation of medical necessity and procedure report.
0201U	Red cell antigen (Yt blood group) genotyping (YT), gene analysis, ACHE (acetylcholinesterase [Cartwright blood group]) exon 2	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0202T	Posterior vertebral joint(s) arthroplasty (e.g., facet joint[s] replacement) including facetectomy, laminectomy, foraminotomy and vertebral column fixation, with or without injection of bone cement, including fluoroscopy, single level, lumbar spine	Pre-Service Review Required	Investigative	Submit history and physical, documentation of medical necessity and procedure report.
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 Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
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 Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.

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0206U	Neurology (Alzheimer disease); cell aggregation using morphometric imaging and protein kinase C-epsilon (PKCe) concentration in response to amylospheroid treatment by ELISA, cultured skin fibroblasts, each reported as positive or negative for Alzheimer disease	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0207U	Neurology (Alzheimer disease); quantitative imaging of phosphorylated ERK1 and ERK2 in response to bradykinin treatment by in situ immunofluorescence, using cultured skin fibroblasts, reported as a probability index for Alzheimer disease (List separately in addition to code for primary procedure)	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0209U	Cytogenomic constitutional (genome-wide) analysis, interrogation of genomic regions for copy number, structural changes and areas of homozygosity for chromosomal abnormalities	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
0210U	Syphilis test, non-treponemal antibody, immunoassay, quantitative (RPR)	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
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 Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. WA PLAN MEMBERS ONLY: No prior authorization required for requests related to stage 3 or 4 cancer; or remittent, recurrent, relapsed, or metastatic cancers. Post-service review may be required through Carelon.

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0212U	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 Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. WA PLAN MEMBERS ONLY: No prior authorization required for requests related to stage 3 or 4 cancer; or remittent, recurrent, relapsed, or metastatic cancers. Post-service review may be required through Carelon.
0213U	Rare diseases (constitutional/heritable disorders), whole genome and mitochondrial DNA sequence analysis, including small sequence changes, deletions, duplications, short tandem repeat gene expansions, and variants in non-uniquely mappable regions, blood or saliva, identification and categorization of genetic variants, each comparator genome (eg, parent, sibling)	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
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 Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
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 Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
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 Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
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 Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
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 Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
0219T	Placement of a posterior intrafacet implant(s), unilateral or bilateral, including imaging and placement of bone graft(s) or synthetic device(s), single level; cervical	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
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	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0220T	Placement of a posterior intrafacet implant(s), unilateral or bilateral, including imaging and placement of bone graft(s) or synthetic device(s), single level; thoracic	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0220U	Oncology (breast cancer), image analysis with artificial intelligence assessment of 12 histologic and immunohistochemical features, reported as a recurrence score	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0221T	Placement of a posterior intrafacet implant(s), unilateral or bilateral, including imaging and placement of bone graft(s) or synthetic device(s), single level; lumbar	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
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	Possible Denial; Medical Records Optional	Investigative	Documentation optional.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
0222T	Placement of a posterior intrafacet implant(s), unilateral or bilateral, including imaging and placement of bone graft(s) or synthetic device(s), single level; each additional vertebral segment (List separately in addition to code for primary procedure)	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
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	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0228U	Oncology (prostate), multianalyte molecular profile by photometric detection of macromolecules adsorbed on nanosponge array slides with machine learning, utilizing first morning voided urine, algorithm reported as likelihood of prostate cancer	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. WA PLAN MEMBERS ONLY: No prior authorization required for requests related to stage 3 or 4 cancer; or remittent, recurrent, relapsed, or metastatic cancers. Post-service review may be required through Carelon.
0229U	BCAT1 (Branched chain amino acid transaminase 1) or IKZF1 (IKAROS family zinc finger 1) (eg, colorectal cancer) promoter methylation analysis	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. WA PLAN MEMBERS ONLY: No prior authorization required for requests related to stage 3 or 4 cancer; or remittent, recurrent, relapsed, or metastatic cancers. Post-service review may be required through Carelon.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
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 Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
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 Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
0232T	Injection(s), platelet rich plasma, any tissue, including image guidance, harvesting and preparation when performed	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
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 Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.

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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 Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
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 Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
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 Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. WA PLAN MEMBERS ONLY: No prior authorization required for requests related to stage 3 or 4 cancer; or remittent, recurrent, relapsed, or metastatic cancers. Post-service review may be required through Carelon.
0236U	SMN1 (survival of motor neuron 1, telomeric) and SMN2 (survival of motor neuron 2, centromeric) (eg, spinal muscular atrophy) full gene analysis, including small sequence changes in exonic and intronic regions, duplications and deletions, and mobile element insertions	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.

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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 Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
0238T	Transluminal peripheral atherectomy, open or percutaneous, including radiological supervision and interpretation; iliac artery, each vessel	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity and procedure report.
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 Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. WA PLAN MEMBERS ONLY: No prior authorization required for requests related to stage 3 or 4 cancer; or remittent, recurrent, relapsed, or metastatic cancers. Post-service review may be required through Carelon.
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 Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. WA PLAN MEMBERS ONLY: No prior authorization required for requests related to stage 3 or 4 cancer; or remittent, recurrent, relapsed, or metastatic cancers. Post-service review may be required through Carelon.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
0242U	Targeted genomic seq analysis panel, solid organ neoplasm, cell-free circulating DNA analysis of 55-74 genes, inerrogation for seq variants, gene copy number amplifications	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. WA PLAN MEMBERS ONLY: No prior authorization required for requests related to stage 3 or 4 cancer; or remittent, recurrent, relapsed, or metastatic cancers. Post-service review may be required through Carelon.
0243U	Obstetrics (preeclampsia), biochemical assay of placental-growth factor, time-resolved fluorescence immunoassay, maternal serum, predictive algorithm reported as a risk score for preeclampsia	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0244U	Oncology DNA, comprehensive genomic profiling, 257 genes, interrogation for single-nucleotide variants, insertions/deletions, copy number alterations, gene rearrangements	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. WA PLAN MEMBERS ONLY: No prior authorization required for requests related to stage 3 or 4 cancer; or remittent, recurrent, relapsed, or metastatic cancers. Post-service review may be required through Carelon.
0245U	Oncology (thyroid) mutation analysis of 10 genes & 37 rna fusions & expression of 4 mrna markers using next-generation sequencing, fine needle aspirate, report incl associated	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. WA PLAN MEMBERS ONLY: No prior authorization required for requests related to stage 3 or 4 cancer; or remittent, recurrent, relapsed, or metastatic cancers. Post-service review may be required through Carelon.

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0247U	Obstetrics (preterm birth), insulin-like growth factor-binding protein 4 (IBP4), sex hormone-binding globulin (SHBG), quantitative measurement by LC-MS/MS, utilizing maternal serum, combined with clinical data, reported as predictive-risk stratification for spontaneous preterm birth	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
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 Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. WA PLAN MEMBERS ONLY: No prior authorization required for requests related to stage 3 or 4 cancer; or remittent, recurrent, relapsed, or metastatic cancers. Post-service review may be required through Carelon.
0252U	Fetal aneuploidy short tandem-repeat comparative analysis, fetal DNA from products of conception, reported as normal (euploidy), monosomy, trisomy, or partial deletion/duplications, mosaicism, and segmental aneuploidy	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
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 Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
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/duplications, mosaicism, and segmental aneuploidy, per embryo tested	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
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 Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
0260U	Rare diseases (constitutional/heritable disorders), identification of copy number variations, inversions, insertions, translocations, and other structural variants by optical genome mapping	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
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 Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. WA PLAN MEMBERS ONLY: No prior authorization required for requests related to stage 3 or 4 cancer; or remittent, recurrent, relapsed, or metastatic cancers. Post-service review may be required through Carelon.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
0263T	Intramuscular autologous bone marrow cell therapy, with preparation of harvested cells, multiple injections, one leg, including ultrasound guidance, if performed; complete procedure including unilateral or bilateral bone marrow harvest	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0264T	Intramuscular autologous bone marrow cell therapy, with preparation of harvested cells, multiple injections, one leg, including ultrasound guidance, if performed; complete procedure excluding bone marrow harvest	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0264U	Rare diseases (constitutional/heritable disorders), identification of copy number variations, inversions, insertions, translocations, and other structural variants by optical genome mapping	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
0265T	Intramuscular autologous bone marrow cell therapy, with preparation of harvested cells, multiple injections, one leg, including ultrasound guidance, if performed; unilateral or bilateral bone marrow harvest only	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
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 Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
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 Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
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 Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
0268U	Hematology (atypical hemolytic uremic syndrome [aHUS]), genomic sequence analysis of 15 genes, blood, buccal swab, or amniotic fluid	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
0269U	Hematology (autosomal dominant congenital thrombocytopenia), genomic sequence analysis of 22 genes, blood, buccal swab, or amniotic fluid	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
0270U	Hematology (congenital coagulation disorders), genomic sequence analysis of 20 genes, blood, buccal swab, or amniotic fluid	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
0271U	Hematology (congenital neutropenia), genomic sequence analysis of 24 genes, blood, buccal swab, or amniotic fluid	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.

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0272U	Hematology (genetic bleeding disorders), genomic sequence analysis of 60 genes and duplication/deletion of plau, blood, buccal swab, or amniotic fluid, comprehensive	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
0273U	Hematology (genetic hyperfibrinolysis, delayed bleeding), genomic sequence analysis of 8 genes (F13A1, F13B, FGA, FGB, FGG, SERPINA1, SERPINE1, SERPINF2, PLAU), blood, buccal swab, or amniotic fluid	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
0274T	Percutaneous laminotomy/laminectomy (interlaminar approach) for decompression of neural elements, with or without the use of an endoscope, single or multiple levels, unilateral or bilateral; cervical or thoracic	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0274U	Hematology (genetic platelet disorders), genomic sequence analysis of 62 genes and duplication/deletion of plau, blood, buccal swab, or amniotic fluid	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
0275T	Percutaneous laminotomy/ laminectomy (intralaminar approach) for decompression of neural elements, with or without the use of an endoscope, single or multiple levels, unilateral or bilateral; lumbar	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0276U	Hematology (inherited thrombocytopenia), genomic sequence analysis of 42 genes, blood, buccal swab, or amniotic fluid	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.

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0277U	Hematology (genetic platelet function disorder), genomic sequence analysis of 40 genes and duplication/deletion of plau, blood, buccal swab, or amniotic fluid	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
0278T	Transcutaneous electrical modulation pain reprocessing (eg, scrambler therapy), each treatment session (includes placement of electrodes)	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0278U	Hematology (genetic thrombosis), genomic sequence analysis of 14 genes, blood, buccal swab, or amniotic fluid	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
0285U	Oncology, response to radiation, cell-free DNA, quantitative branched chain DNA amplification, plasma, reported as a radiation toxicity score	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. WA PLAN MEMBERS ONLY: No prior authorization required for requests related to stage 3 or 4 cancer; or remittent, recurrent, relapsed, or metastatic cancers. Post-service review may be required through Carelon.
0286U	CEP72 (centrosomal protein, 72-KDa), NUDT15 (nudix hydrolase 15) and TPMT (thiopurine S-methyltransferase) (eg, drug metabolism) gene analysis, common variants	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
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 Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. WA PLAN MEMBERS ONLY: No prior authorization required for requests related to stage 3 or 4 cancer; or remittent, recurrent, relapsed, or metastatic cancers. Post-service review may be required through Carelon.
0288U	Oncology (lung), mRNA, quantitative PCR analysis of 11 genes (BAG1, BRCA1, CDC6, CDK2AP1, ERBB3, FUT3, IL11, LCK, RND3, SH3BGR, WNT3A) and 3 reference genes (ESD, TBP, YAP1), formalin-fixed paraffin-embedded (FFPE) tumor tissue, algorithmic interpretation reported as a recurrence risk score	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. WA PLAN MEMBERS ONLY: No prior authorization required for requests related to stage 3 or 4 cancer; or remittent, recurrent, relapsed, or metastatic cancers. Post-service review may be required through Carelon.
0289U	Neurology (Alzheimer disease), mRNA, gene expression profiling by RNA sequencing of 24 genes, whole blood, algorithm reported as predictive risk score	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
0290U	Pain management, mRNA, gene expression profiling by RNA sequencing of 36 genes, whole blood, algorithm reported as predictive risk score	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
0291U	Psychiatry (mood disorders), mRNA, gene expression profiling by RNA sequencing of 144 genes, whole blood, algorithm reported as predictive risk score	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.

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0292U	Psychiatry (stress disorders), mRNA, gene expression profiling by RNA sequencing of 72 genes, whole blood, algorithm reported as predictive risk score	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
0293U	Psychiatry (suicidal ideation), mRNA, gene expression profiling by RNA sequencing of 54 genes, whole blood, algorithm reported as predictive risk score	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
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 Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
0295U	Oncology (breast ductal carcinoma in situ), protein expression profiling by immunohistochemistry of 7 proteins (COX2, FOXA1, HER2, Ki-67, p16, PR, SIAH2), with 4 clinicopathologic factors (size, age, margin status, palpability), utilizing formalin-fixed paraffin-embedded (FFPE) tissue, algorithm reported as a recurrence risk score	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
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 Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. WA PLAN MEMBERS ONLY: No prior authorization required for requests related to stage 3 or 4 cancer; or remittent, recurrent, relapsed, or metastatic cancers. Post-service review may be required through Carelon.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
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 Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. WA PLAN MEMBERS ONLY: No prior authorization required for requests related to stage 3 or 4 cancer; or remittent, recurrent, relapsed, or metastatic cancers. Post-service review may be required through Carelon.
0298U	Oncology (pan tumor), whole transcriptome sequencing of paired malignant and normal RNA specimens, fresh or formalin-fixed paraffin-embedded (FFPE) tissue, blood or bone marrow, comparative sequence analyses and expression level and chimeric transcript identification	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. WA PLAN MEMBERS ONLY: No prior authorization required for requests related to stage 3 or 4 cancer; or remittent, recurrent, relapsed, or metastatic cancers. Post-service review may be required through Carelon.
0299U	Oncology (pan tumor), whole genome optical genome mapping of paired malignant and normal DNA specimens, fresh frozen tissue, blood, or bone marrow, comparative structural variant identification	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. WA PLAN MEMBERS ONLY: No prior authorization required for requests related to stage 3 or 4 cancer; or remittent, recurrent, relapsed, or metastatic cancers. Post-service review may be required through Carelon.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
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 Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. WA PLAN MEMBERS ONLY: No prior authorization required for requests related to stage 3 or 4 cancer; or remittent, recurrent, relapsed, or metastatic cancers. Post-service review may be required through Carelon.
0306U	Oncology (minimal residual disease [MRD]), next-generation targeted sequencing analysis, cell-free DNA, initial (baseline) assessment to determine a patient specific panel for future comparisons to evaluate for MRD	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. WA PLAN MEMBERS ONLY: No prior authorization required for requests related to stage 3 or 4 cancer; or remittent, recurrent, relapsed, or metastatic cancers. Post-service review may be required through Carelon.
0307U	Oncology (minimal residual disease [MRD]), next-generation targeted sequencing analysis of a patient-specific panel, cell-free DNA, subsequent assessment with comparison to previously analyzed patient specimens to evaluate for MRD	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. WA PLAN MEMBERS ONLY: No prior authorization required for requests related to stage 3 or 4 cancer; or remittent, recurrent, relapsed, or metastatic cancers. Post-service review may be required through Carelon.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
0312U	Autoimmune diseases (eg, systemic lupus erythematosus [SLE]), analysis of 8 IgG autoantibodies and 2 cell-bound complement activation products using enzyme-linked immunosorbent immunoassay (ELISA), flow cytometry and indirect immunofluorescence, serum, or plasma and whole blood, individual components reported along with an algorithmic SLE-likelihood assessment	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
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 Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. WA PLAN MEMBERS ONLY: No prior authorization required for requests related to stage 3 or 4 cancer; or remittent, recurrent, relapsed, or metastatic cancers. Post-service review may be required through Carelon.
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 Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. WA PLAN MEMBERS ONLY: No prior authorization required for requests related to stage 3 or 4 cancer; or remittent, recurrent, relapsed, or metastatic cancers. Post-service review may be required through Carelon.

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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 Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. WA PLAN MEMBERS ONLY: No prior authorization required for requests related to stage 3 or 4 cancer; or remittent, recurrent, relapsed, or metastatic cancers. Post-service review may be required through Carelon.
0317U	Oncology (lung cancer), four-probe FISH (3q29, 3p22.1, 10q22.3, 10cen) assay, whole blood, predictive algorithm-generated evaluation reported as decreased or increased risk for lung cancer	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. WA PLAN MEMBERS ONLY: No prior authorization required for requests related to stage 3 or 4 cancer; or remittent, recurrent, relapsed, or metastatic cancers. Post-service review may be required through Carelon.
0318U	Pediatrics (congenital epigenetic disorders), whole genome methylation analysis by microarray for 50 or more genes, blood	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
0319U	Nephrology (renal transplant), RNA expression by select transcriptome sequencing, using pretransplant peripheral blood, algorithm reported as a risk score for early acute rejection	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
0320U	Nephrology (renal transplant), RNA expression by select transcriptome sequencing, using posttransplant peripheral blood, algorithm reported as a risk score for acute cellular rejection	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.

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0326U	Targeted genomic sequence analysis panel, solid organ neoplasm, cell-free circulating DNA analysis of 83 or more genes, interrogation for sequence variants, gene copy number amplifications, gene rearrangements, microsatellite instability and tumor mutational burden	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. WA PLAN MEMBERS ONLY: No prior authorization required for requests related to stage 3 or 4 cancer; or remittent, recurrent, relapsed, or metastatic cancers. Post-service review may be required through Carelon.
0327U	Fetal aneuploidy (trisomy 13, 18, and 21), DNA sequence analysis of selected regions using maternal plasma, algorithm reported as a risk score for each trisomy, includes sex reporting, if performed	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
0329U	Oncology (neoplasia), exome and transcriptome sequence analysis for sequence variants, gene copy number amplifications and deletions, gene rearrangements, microsatellite instability and tumor mutational burden utilizing DNA and RNA from tumor with DNA from normal blood or saliva for subtraction, report of clinically significant mutation(s) with therapy associations	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. WA PLAN MEMBERS ONLY: No prior authorization required for requests related to stage 3 or 4 cancer; or remittent, recurrent, relapsed, or metastatic cancers. Post-service review may be required through Carelon.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
0331U	Oncology (hematolymphoid neoplasia), optical genome mapping for copy number alterations and gene rearrangements utilizing DNA from blood or bone marrow, report of clinically significant alterations	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. WA PLAN MEMBERS ONLY: No prior authorization required for requests related to stage 3 or 4 cancer; or remittent, recurrent, relapsed, or metastatic cancers. Post-service review may be required through Carelon.
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 Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. WA PLAN MEMBERS ONLY: No prior authorization required for requests related to stage 3 or 4 cancer; or remittent, recurrent, relapsed, or metastatic cancers. Post-service review may be required through Carelon.
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 Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. WA PLAN MEMBERS ONLY: No prior authorization required for requests related to stage 3 or 4 cancer; or remittent, recurrent, relapsed, or metastatic cancers. Post-service review may be required through Carelon.

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0334U	Oncology (solid organ), targeted genomic sequence analysis, formalin-fixed paraffin-embedded (FFPE) tumor tissue, DNA analysis, 84 or more genes, interrogation for sequence variants, gene copy number amplifications, gene rearrangements, microsatellite instability and tumor mutational burden	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. WA PLAN MEMBERS ONLY: No prior authorization required for requests related to stage 3 or 4 cancer; or remittent, recurrent, relapsed, or metastatic cancers. Post-service review may be required through Carelon.
0335T	Insertion of sinus tarsi implant.	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
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 Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
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 Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
0337U	Oncology (plasma cell disorders and myeloma), circulating plasma cell immunologic selection, identification, morphological characterization, and enumeration of plasma cells based on differential CD138, CD38, CD19, and CD45 protein biomarker expression, peripheral blood	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0338U	Oncology (solid tumor), circulating tumor cell selection, identification, morphological characterization, detection and enumeration based on differential EpCAM, cytokeratins 8, 18, and 19, and CD45 protein biomarkers, and quantification of HER2 protein biomarker-expressing cells, peripheral blood	Possible Denial; Medical Records Optional	Investigative	Documentation optional.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
0339U	Oncology (prostate), mRNA expression profiling of HOXC6 and DLX1, reverse transcription polymerase chain reaction (RT-PCR), first-void urine following digital rectal examination, algorithm reported as probability of high-grade cancer	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. WA PLAN MEMBERS ONLY: No prior authorization required for requests related to stage 3 or 4 cancer; or remittent, recurrent, relapsed, or metastatic cancers. Post-service review may be required through Carelon.
0340U	Oncology (pan-cancer), analysis of minimal residual disease (MRD) from plasma, with assays personalized to each patient based on prior next-generation sequencing of the patient's tumor and germline DNA, reported as absence or presence of MRD, with disease-burden correlation, if appropriate	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. WA PLAN MEMBERS ONLY: No prior authorization required for requests related to stage 3 or 4 cancer; or remittent, recurrent, relapsed, or metastatic cancers. Post-service review may be required through Carelon.
0341U	Fetal aneuploidy DNA sequencing comparative analysis, fetal DNA from products of conception, reported as normal (euploidy), monosomy, trisomy, or partial deletion/duplication, mosaicism, and segmental aneuploid	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
0342U	Oncology (pancreatic cancer), multiplex immunoassay of C5, C4, cystatin C, factor B, osteoprotegerin (OPG), gelsolin, IGFBP3, CA125 and multiplex electrochemiluminescent immunoassay (ECLIA) for CA19-9, serum, diagnostic algorithm reported qualitatively as positive, negative, or borderline	Possible Denial; Medical Records Optional	Investigative	Documentation optional.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
0343U	Oncology (prostate), exosome-based analysis of 442 small noncoding RNAs (sncRNAs) by quantitative reverse transcription polymerase chain reaction (RT-qPCR), urine, reported as molecular evidence of no-, low-, intermediate- or high-risk of prostate cancer	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. WA PLAN MEMBERS ONLY: No prior authorization required for requests related to stage 3 or 4 cancer; or remittent, recurrent, relapsed, or metastatic cancers. Post-service review may be required through Carelon.
0344U	Hepatology (nonalcoholic fatty liver disease [NAFLD]), semiquantitative evaluation of 28 lipid markers by liquid chromatography with tandem mass spectrometry (LC-MS/MS), serum, reported as at-risk for nonalcoholic steatohepatitis (NASH) or not NASH	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0345T	Transcatheter mitral valve repair percutaneous approach via the coronary sinus	Prior Authorization Required	Medical Necessity	Submit documentation of medical necessity, operative report
0345U	Psychiatry (eg, depression, anxiety, attention deficit hyperactivity disorder [ADHD]), genomic analysis panel, variant analysis of 15 genes, including deletion/duplication analysis of CYP2D6	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
0347U	Drug metabolism or processing (multiple conditions), whole blood or buccal specimen, DNA analysis, 16 gene report, with variant analysis and reported phenotypes	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
0348U	Drug metabolism or processing (multiple conditions), whole blood or buccal specimen, DNA analysis, 25 gene report, with variant analysis and reported phenotypes	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.

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0349U	Drug metabolism or processing (multiple conditions), whole blood or buccal specimen, DNA analysis, 27 gene report, with variant analysis, including reported phenotypes and impacted gene-drug interactions	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
0350U	Drug metabolism or processing (multiple conditions), whole blood or buccal specimen, DNA analysis, 27 gene report, with variant analysis and reported phenotypes	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
0355U	APOL1 (apolipoprotein L1) (eg, chronic kidney disease), risk variants (G1, G2)	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
0356U	Oncology (oropharyngeal or anal), evaluation of 17 DNA biomarkers using droplet digital PCR (ddPCR), cell-free DNA, algorithm reported as a prognostic risk score for cancer recurrence	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
0358T	Bioelectrical impedance analysis whole body composition assessment, with interpretation and report	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0358U	Neurology (mild cognitive impairment), analysis of B-amyloid 1-42 and 1-40, chemiluminescence enzyme immunoassay, cerebral spinal fluid, reported as positive, likely positive, or negative	Pre-Service Review Required	Investigative	Submit history and physical, documentation of medical necessity.

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0360U	Oncology (lung), enzyme-linked immunosorbent assay (ELISA) of 7 autoantibodies (p53, NY-ESO-1, CAGE, GBU4-5, SOX2, MAGE A4, and HuD), plasma, algorithm reported as a categorical result for risk of malignancy	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0361U	Neurofilament light chain, digital immunoassay, plasma, quantitative	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0362U	Oncology (papillary thyroid cancer), gene-expression profiling via targeted hybrid capture–enrichment RNA sequencing of 82 content genes and 10 housekeeping genes, fine needle aspirate or formalin-fixed paraffin embedded (FFPE) tissue, algorithm reported as one of three molecular subtypes	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
0363U	Oncology (urothelial), mRNA, geneexpression profiling by real-time quantitative PCR of 5 genes (MDK, HOXA13, CDC2 [CDK1], IGFBP5, and CXCR2), utilizing urine, algorithm incorporates age, sex, smoking history, and macrohematuria frequency, reported as a risk score for having urothelial carcinoma	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
0364U	Oncology (hematolymphoid neoplasm), genomic sequence analysis using multiplex (PCR) and next-generation sequencing with algorithm, quantification of dominant clonal sequence(s), reported as presence or absence of minimal residual disease (MRD) with quantitation of disease burden, when appropriate	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
0365U	Oncology (bladder), 10 protein biomarkers (A1AT, ANG, APOE, CA9, IL8, MMP9, MMP10, PAI1, SDC1 and VEGFA) by immunoassays, urine, diagnostic, algorithm including patient's age, race and gender reported as a probability of harboring urothelial cancer	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0366U	Oncology (bladder), analysis of 10 protein biomarkers (A1AT, ANG, APOE, CA9, IL8, MMP9, MMP10, PAI1, SDC1 and VEGFA) by immunoassays, urine, algorithm reported as a probability of recurrent bladder cancer	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0367U	Oncology (bladder), analysis of 10 protein biomarkers (A1AT, ANG, APOE, CA9, IL8, MMP9, MMP10, PAI1, SDC1 and VEGFA) by immunoassays, urine, diagnostic algorithm reported as a risk score for probability of rapid recurrence of recurrent or persistent cancer following transurethral resection	Possible Denial; Medical Records Optional	Investigative	Documentation optional.

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0368U	Oncology (colorectal cancer), evaluation for mutations of APC, BRAF, CTNNB1, KRAS, NRAS, PIK3CA, SMAD4, and TP53, and methylation markers (MYO1G, KCNQ5, C9ORF50, FLI1, CLIP4, ZNF132 and TWIST1), multiplex quantitative polymerase chain reaction (qPCR), circulating cell-free DNA (cfDNA), plasma, report of risk score for advanced adenoma or colorectal cancer	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
0371U	Infectious agent detection by nucleic acid genitourinary pathogen, semiquantitative identification, DNA from 16 bacterial organisms & 1 fungal organism, multiplex amplified	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0372U	Infectious disease, antibiotic-resistance gene detection, multiplex amplified probe technique, urine, reported as an antimicrobial stewardship risk score	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0373U	Infectious agent detection by nucleic acid respiratory tract infection, 17 bacteria, 8 fungus, 13 virus & 16 antibiotic-resistance genes, multiplex amplified probe technique	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0374U	Infectious agent detection by nucleic acid genitourinary pathogens, identification of 21 bacterial & fungal organisms and identification of 32 associated antibiotic-resistance genes, multiplex amplified probe technique, urine	Possible Denial; Medical Records Optional	Investigative	Documentation optional.

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0375U	Oncology (ovarian), biochemical assays of 7 proteins (follicle stimulating hormone, human epididymis protein 4, apolipoprotein A-1, transferrin, beta-2 macroglobulin, prealbumin [ie, transthyretin], and cancer antigen 125), algorithm reported as ovarian cancer risk score	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0376U	Oncology (prostate cancer), image analysis of at least 128 histologic features and clinical factors, prognostic algorithm determining the risk of distant metastases, and prostate cancer-specific mortality, includes predictive algorithm to androgen deprivation-therapy response, if appropriate	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0377U	Cardiovascular disease, quantification of advanced serum or plasma lipoprotein profile, by nuclear magnetic resonance (NMR) spectrometry with report of a lipoprotein profile	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0378U	RFC1 (replication factor C subunit 1), repeat expansion variant analysis by traditional and repeat-primed PCR, blood, saliva, or buccal swab	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
0379U	Targeted genomic sequence analysis panel, solid organ neoplasm, DNA (523 genes) and RNA (55 genes) by next-generation sequencing, interrogation for sequence variants, gene copy number amplifications, gene rearrangements, microsatellite instability, and tumor mutational burden	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.

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0384U	Nephrology carboxymethyllsine, methylgloxal hydroimidazolone, and carboxyethyl lysine by liquid chromatography with tandem mass spectrometry & HBA1C 4	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0385U	Nephrology apolipoprotein A4, CD5 antigen-like and insulin-like growth factor binding protein 3 by enzyme-linked immunoassay plasma, algorithm combining results with HDL, estimated glomerular filtration rate (GFR) and clinical data reported as a risk score for developing diabetic kidney disease	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0388U	Oncology (non-small cell lung cancer), next generation sequencing with identification of single nucleotide variants, copy number variants, insertions and deletions, and structural variants in 37 cancer related genes, plasma, with report of alterations detected	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
0389U	Pediatric febrile illness (Kawasaki disease [KD]), interferon alphainducible protein 27 (IFI27) and mast cell-expressed membrane protein 1 (MCEMP1), RNA, using reverse transcription polymerase chain reaction (RT-qPCR), blood, reported as a risk score for KD	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
0390U	Obstetrics (preeclampsia), kinase insert domain receptor (KDR), Endoglin (ENG), and retinol-binding protein 4 (RBP4), by immunoassay, serum, algorithum reported as risk score	Possible Denial; Medical Records Optional	Investigative	Documentation optional.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
0391U	Oncology (solid tumor), DNA and RNA by next-generation sequencing, utilizing formalin-fixed paraffin-embedded (FFPE) tissue, 437 genes, interpretive report for single nucleotide variants, splicesite variants, insertions/deletions, copy number alterations, gene fusions, tumor mutational burden, and microsatellite instability, with algorithm quantifying immunotherapy response score	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
0392U	Drug metabolism (depression, anxiety, attention deficit hyperactivity disorder [ADHD]), gene-drug interactions, variant analysis of 16 genes, including deletion/duplication analysis of CYP2D6, reported as impact of gene-drug interaction for each drug	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
0393U	Neurology (eg, Parkinson disease, dementia with Lewy bodies), cerebrospinal fluid (CSF), detection of misfolded ?-synuclein protein by seed amplification assay, qualitative	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0394T	High dose rate electronic brachytherapy, skin surface application, per fraction, includes basic dosimetry, when performed	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0395U	Oncology (lung), multi-omics (microbial DNA by shotgun nextgeneration sequencing and carcinoembryonic antigen and osteopontin by immunoassay), plasma, algorithm reported as malignancy risk for lung nodules in early-stage disease	Possible Denial; Medical Records Optional	Investigative	Documentation optional.

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0398U	Gastroenterology (Barrett esophagus), P16, RUNX3, HPP1, and FBN1 DNA methylation analysis using PCR, formalin-fixed paraffin-embedded (FFPE) tissue, algorithm reported as risk score for progression to high-grade dysplasia or cancer	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0400U	Obstetrics (expanded carrier screening), 145 genes by nextgeneration sequencing, fragment analysis and multiplex ligationdependent probe amplification, DNA, reported as carrier positive or negative	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
0401U	Cardiology (coronary heart disease [CAD]), 9 genes (12 variants), targeted variant genotyping, blood, saliva, or buccal swab, algorithm reported as a genetic risk score for a coronary event	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
0403U	Oncology (prostate), MRNA, gene expression profiling of 18 genes, first-catch post-digital rectal exam urine, algorithm reported as percentage of detecting prostate cancer	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
0404U	Oncology (breast), semiquantitative measurement of thymidine kinase activity by immunoassay, serum, results reported as risk of disease progression	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0405U	Oncology (pancreatic), 59 methylation haplotype block markers, next-generation sequencing, plasma, reported as cancer signal detected or not detected	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.

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0406U	Oncology (lung), flow cytometry, sputum, 5 markers (meso-tetra [4-carboxyphenyl] porphyrin [TCPP]. CD206, CD66B, CD3, CD19), algorithm reported as likelihood of lung cancer	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0408T	Insertion or replacement of permanent cardiac contractility modulation system, including contractility evaluation when performed, and programming of sensing and therapeutic parameters; pulse generator with transvenous electrodes	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0409U	Oncology (solid tumor), DNA (80 genes) and RNA (36 genes), by next-generation sequencing from plasma, including single nucleotide variants, insertions/deletions, copy number alterations	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
0410U	Oncology (pancreatic), DNA, whole genome sequencing with 5-hydroxymethylcytosine enrichment, whole blood or plasma, algorithm reported as cancer detected or not detected	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
0411U	Psychiatry (depression, anxiety, attention deficit hyperactivity disorder), genomic analysis panel, variant analysis of 15 genes, including deletion/duplication analysis of CYP2D6	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
0412U	Beta amyloid, A?42/40 ratio, immunoprecipitation with quantitation by liquid chromatography with tandem mass spectrometry & qualitative APOE isoform specific proteotyping	Possible Denial; Medical Records Optional	Investigative	Documentation optional.

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0413U	Oncology optical genome mapping for copy number alterations, aneuploidy & balanced/complex structural rearrangements, DNA from blood or bone marrow, RPT of clinically significance alt	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
0414U	Oncology (lung), augmentative algorithmic analysis of digitized whole slide imaging for 8 genes & KRAS G12C & PD-L1, if performed, formalin-fixed paraffin-embedded tissue report	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
0415U	Cardiovascular disease IL-16, FAS, Fasligand, HGF, CTACK, Eotaxin & MCP-3 by immunoassay combined with age, sex, family and personal history of diabetes, blood algorithm RPT 5 year score ACS	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0417U	Rare diseases whole mitochondrial genome sequence with heteroplasmy detection & deletion analysis, nuclear-encoded mitochondrial gene analysis of 335 nuclear genes, including sequence changes	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
0418U	Oncology (breast), augmentative algorithmic analysis of digitized whole slide imaging of 8 histologic and immunohistochemical features, reported as a recurrence score	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0419U	Neuropsychiatry (eg depression, anxiety,) genomic sequence analysis panel, variant analysis of 13 genes, saliva or buccal swab, report of each gene phenotype	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
0420U	Oncology (urothelial), MRNA expression profiling by real-time quantitative PCR of MDK, HOXA13, CDC2, IGFBP5 & CXCR2 in comb w/ droplet digital PCR analysis of 6 single-nucleotide polymorphisms (SNPS) genes TERT and FGFR3, urine, algorithm reported as a risk score for urothelial carcinoma	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
0421T	Transurethral waterjet ablation of prostate, including control of post-operative bleeding, including ultrasound guidance, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, and internal urethrotomy are included when performed)	Prior Authorization Required	Investigative	Submit history and physical, documentation of medical necessity and procedure report.
0421U	Oncology (colorectal) screening, quantitative real-time target & signal amplification of 8 RNA markers & fecal hemoglobin, algorithm reported as A+ or - for colorectal cancer	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0422U	Oncology (pan-solid tumor) analysis of DNA biomarker response to anti-cancer therapy using cell-free circulating DNA, biomarker comparison to a previous baseline pre-treatment	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. WA PLAN MEMBERS ONLY: No prior authorization required for requests related to stage 3 or 4 cancer; or remittent, recurrent, relapsed, or metastatic cancers. Post-service review may be required through Carelon.

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0423U	Psychiatry (eg, depression, anxiety) genomic analysis panel, including variant analysis of 26 genes, buccal swab report including metabolizer status & risk of drug toxicity by condition	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
0424U	Oncology (prostate), exosome-based analysis of 53 small noncoding RNAs by quantitative reverse transcription polymerase chain reaction urine, reported as no molecular evidence	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
0425U	Genome (eg, unexplained constitutional or heritable disorder or syndrome), rapid sequence analysis, each comparator genome (eg parents, siblings)	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
0426U	Genome (eg, unexplained constitutional or heritable disorder or syndrome), ultra-rapid sequence analysis	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
0430U	Gastroenterology, malabsorption evaluation of alpha-1-antitrypsin, calprotectin, pancreatic elastase and reducing substances, feces, quantitative	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0433U	Oncology (prostate), 5 DNA regulatory markers by quantitative PCR, whole blood, algorithm, including prostate-specific antigen, reported as likelihood of cancer	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
0434U	Drug metabolism (adverse drug reactions and drug response), genomic analysis panel, variant analysis of 25 genes with reported phenotypes	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.

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0435U	Oncology, chemotherapeutic drug cytotoxicity assay of cancer stem cells, from cultured CSCS and primary tumor cells, categorical drug response reported based on cytotoxicity	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0436U	Oncology (lung), plasma analysis of 388 proteins, using aptamer-based proteomics technology, predictive algorithm reported as clinical benefit from immune checkpoint inhibitor	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0437U	Psychiatry (anxiety disorders), MRNA, gene expression profiling by RNA sequencing of 15 biomarkers, whole blood, algorithm reported as predictive risk score	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
0438U	Drug metabolism (adverse drug reactions & drug response), buccal specimen, gene-drug interactions, variant analysis of 33 genes including deletion/duplication analysis of CYPD6	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.

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0439U	Cardiology (coronary heart disease [CHD]), DNA, analysis of 5 single-nucleotide polymorphisms (SNPs) (rs11716050 [LOC105376934], rs6560711 [WDR37], rs3735222 [SCIN/LOC107986769], rs6820447 [intergenic], and rs9638144 [ESYT2]) and 3 DNA methylation markers (cg00300879 [transcription start site {TSS200} of CNKSR1], cg09552548 [intergenic], and cg14789911 [body of SPATC1L]), qPCR and digital PCR, whole blood, algorithm reported as a 4-tiered risk score for a 3-year risk of symptomatic CHD	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
0440U	Cardiology (coronary heart disease) DNA analysis of 10 single-nucleotide polymorphisms (rs710987[LINC010019],rs1333048[CDKN2B-AS1],rs12129789 [KCND3],rs942317 [KTN1-AS1],rs1441433 [PPP3CA],rs2869675 [PREX1],rs4639796 [ZBTB41],rs4376434 [LINC00972],rs12714414 [TMEM18],rs7585056 [TMEM18]) & 6 DNA methylation markers (cg03725309 [SARS1],cg12586707 [CXCL1,cg04988978 [MPO],cg17901584 [DHCR24-DT],cg21161138 [AHRR],cg12655112 [EHD4]),qPCR, digital PCR, whole blood, algorithm reported as detected or not	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
0441T	Ablation, percutaneous, cryoablation, includes imaging guidance; lower extremity distal/peripheral nerve	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0441U	Infectious disease (bacterial, fungal, or viral infection), semiquantitative biomechanical assessment (via deformability cytometry), whole blood, with algorithmic analysis and result reported as an index	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0442U	Infectious disease (respiratory infection), Myxovirus resistance protein A (MxA) and C-reactive protein (CRP), fingerstick whole blood specimen, each biomarker reported as present or absent	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0443U	Neurofilament light chain (NfL), ultra-sensitive immunoassay, serum or cerebrospinal fluid	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0444U	Oncology (solid organ neoplasia), targeted genomic sequence analysis panel of 361 genes, interrogation for gene fusions, translocations, or other rearrangements, using DNA from formalin fixed paraffin-embedded (FFPE) tumor tissue, report of clinically significant variant(s)	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
0445U	?-amyloid (Abeta42) and phospho tau (181P) (pTau181), electrochemiluminescent immunoassay (ECLIA), cerebral spinal fluid, ratio reported as positive or negative for amyloid pathology	Pre-Service Review Required	Medical Necessity	Submit history and physical, documentation of medical necessity.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
0446U	Autoimmune diseases (systemic lupus erythematosus [SLE]), analysis of 10 cytokine soluble mediator biomarkers by immunoassay, plasma, individual components reported with an algorithmic risk score for current disease activity	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0447U	Autoimmune diseases (systemic lupus erythematosus [SLE]), analysis of 11 cytokine soluble mediator biomarkers by immunoassay, plasma, individual components reported with an algorithmic prognostic risk score for developing a clinical flare	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0449U	Carrier screening for severe inherited conditions (eg, cystic fibrosis, spinal muscular atrophy, beta hemoglobinopathies [including sickle cell disease], alpha thalassemia), regardless of race or self-identified ancestry, genomic sequence analysis panel, must include analysis of 5 genes (CFTR, SMN1, HBB, HBA1, HBA2)	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
0450U	Oncology (multiple myeloma), liquid chromatography with tandem mass spectrometry (LC-MS/MS), monoclonal paraprotein sequencing analysis, serum, results reported as baseline presence or absence of detectable clonotypic peptides	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0451U	Oncology (multiple myeloma), LC-MS/MS, peptide ion quantification, serum, results compared with baseline to determine monoclonal paraprotein abundance	Possible Denial; Medical Records Optional	Investigative	Documentation optional.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
0452U	Oncology (bladder), methylated PENK DNA detection by linear target enrichment-quantitative methylation-specific real-time PCR (LTE-qMSP), urine, reported as likelihood of bladder cancer	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
0453U	Oncology (colorectal cancer), cell-free DNA (cfDNA), methylation-based quantitative PCR assay (SEPTIN9, IKZF1, BCAT1, Septin9-2, VAV3, BCAN), plasma, reported as presence or absence of circulating tumor DNA (ctDNA)	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
0454U	Rare diseases (constitutional/heritable disorders), identification of copy number variations, inversions, insertions, translocations, and other structural variants by optical genome mapping	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
0457U	Perfluoroalkyl substances (PFAS) (eg, perfluorooctanoic acid, perfluorooctane sulfonic acid), 9 PFAS compounds by LC-MS/MS, plasma or serum, quantitative	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0458U	Oncology (breast cancer), S100A8 and S100A9, by enzyme-linked immunosorbent assay (ELISA), tear fluid with age, algorithm reported as a risk score	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0459U	B-amyloid (Abeta42) and total tau (tTau), electrochemiluminescent immunoassay (ECLIA), cerebral spinal fluid, ratio reported as positive or negative for amyloid pathology	Pre-Service Review Required	Medical Necessity	Submit history and physical, documentation of medical necessity.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
0460U	Oncology, whole blood or buccal, DNA single-nucleotide polymorphism (SNP) genotyping by real-time PCR of 24 genes, with variant analysis and reported phenotypes	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
0461U	Oncology, pharmacogenomic analysis of single-nucleotide polymorphism (SNP) genotyping by real-time PCR of 24 genes, whole blood or buccal swab, with variant analysis, including impacted gene-drug interactions and reported phenotypes	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
0462U	Melatonin levels test, sleep study, 7 or 9 sample melatonin profile (cortisol optional), enzyme-linked immunosorbent assay (ELISA), saliva, screening/preliminary	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0463U	Oncology (cervix), mRNA gene expression profiling of 14 biomarkers (E6 and E7 of the highest-risk human papillomavirus [HPV] types 16, 18, 31, 33, 45, 52, 58), by real-time nucleic acid sequence-based amplification (NASBA), exo- or endocervical epithelial cells, algorithm reported as positive or negative for increased risk of cervical dysplasia or cancer for each biomarker	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0465U	Oncology (urothelial carcinoma), DNA, quantitative methylation-specific PCR of 2 genes (ONECUT2, VIM), algorithmic analysis reported as positive or negative	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
0466U	Cardiology (coronary artery disease [CAD]), DNA, genome-wide association studies (564856 single-nucleotide polymorphisms [SNPs], targeted variant genotyping), patient lifestyle and clinical data, buccal swab, algorithm reported as polygenic risk to acquired heart disease	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
0467U	Oncology (bladder), DNA, next-generation sequencing (NGS) of 60 genes and whole genome aneuploidy, urine, algorithms reported as minimal residual disease (MRD) status positive or negative and quantitative disease burden	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
0468U	Hepatology (nonalcoholic steatohepatitis [NASH]), miR-34a-5p, alpha 2-macroglobulin, YKL40, HbA1c, serum and whole blood, algorithm reported as a single score for NASH activity and fibrosis	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0469T	Retinal polarization scan, ocular screening with on-site automated results, bilateral	Possible Denial; Medical Records Optional	Investigative	Documentation optional.

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0469U	Rare diseases (constitutional/heritable disorders), whole genome sequence analysis for chromosomal abnormalities, copy number variants, duplications/deletions, inversions, unbalanced translocations, regions of homozygosity (ROH), inheritance pattern that indicate uniparental disomy (UPD), and aneuploidy, fetal sample (amniotic fluid, chorionic villus sample, or products of conception), identification	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
0470U	Oncology (oropharyngeal), detection of minimal residual disease by next-generation sequencing (NGS) based quantitative evaluation of 8 DNA targets, cell-free HPV 16 and 18 DNA from plasma	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0471U	Oncology (colorectal cancer), qualitative real-time PCR of 35 variants of KRAS and NRAS genes (exons 2, 3, 4), formalin-fixed paraffin-embedded (FFPE), predictive, identification of detected mutations	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
0472T	Device evaluation, interrogation, and initial programming of intraocular retinal electrode array (eg, retinal prosthesis), in person, with iterative adjustment of the implantable device to test functionality, select optimal permanent programmed values with analysis, including visual training, with review and report by a qualified health care professional	Possible Denial; Medical Records Optional	Investigative	Documentation optional.

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0472U	Carbonic anhydrase VI (CA VI), parotid specific/secretory protein (PSP) and salivary protein (SP1) IgG, IgM, and IgA antibodies, enzyme-linked immunosorbent assay (ELISA), semiqualitative, blood, reported as predictive evidence of early Sjogren syndrome	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0473T	Device evaluation and interrogation of intraocular retinal electrode array (eg, retinal prosthesis), in person, including reprogramming and visual training, when performed, with review and report by a qualified health care professional	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0473U	Oncology (solid tumor), next-generation sequencing (NGS) of DNA from formalin-fixed paraffin-embedded (FFPE) tissue with comparative sequence analysis from a matched normal specimen (blood or saliva), 648 genes, interrogation for sequence variants, insertion and deletion alterations, copy number variants, rearrangements, microsatellite instability, and tumor-mutation burden	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
0474U	Hereditary pan-cancer (eg, hereditary sarcomas, hereditary endocrine tumors, hereditary neuroendocrine tumors, hereditary cutaneous melanoma), genomic sequence analysis panel of 88 genes with 20 duplications/deletions using next-generation sequencing (NGS), Sanger sequencing, blood or saliva, reported as positive or negative for germline variants, each gene	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
0475U	Hereditary prostate cancer-related disorders, genomic sequence analysis panel using next-generation sequencing (NGS), Sanger sequencing, multiplex ligation-dependent probe amplification (MLPA), and array comparative genomic hybridization (CGH), evaluation of 23 genes and duplications/deletions when indicated, pathologic mutations reported with a genetic risk score for prostate cancer	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
0476U	Drug metabolism, psychiatry (eg, major depressive disorder, general anxiety disorder, attention deficit hyperactivity disorder [ADHD], schizophrenia), whole blood, buccal swab, and pharmacogenomic genotyping of 14 genes and CYP2D6 copy number variant analysis and reported phenotypes	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
0477U	Drug metabolism, psychiatry (eg, major depressive disorder, general anxiety disorder, attention deficit hyperactivity disorder [ADHD], schizophrenia), whole blood, buccal swab, and pharmacogenomic genotyping of 14 genes and CYP2D6 copy number variant analysis, including impacted gene-drug interactions and reported phenotypes	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
0478U	Oncology (non-small cell lung cancer), DNA and RNA, digital PCR analysis of 9 genes (EGFR, KRAS, BRAF, ALK, ROS1, RET, NTRK 1/2/3, ERBB2, and MET) in formalin-fixed paraffin-embedded (FFPE) tissue, interrogation for single-nucleotide variants, insertions/deletions, gene rearrangements, and reported as actionable detected variants for therapy selection	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
0479T	Fractional ablative laser fenestration of burn and traumatic scars for functional improvement; first 100 cm2 or part thereof, or 1% of body surface area of infants and children	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0479U	Tau, phosphorylated, pTau217	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0480T	Fractional ablative laser fenestration of burn and traumatic scars for functional improvement; each additional 100 cm2, or each additional 1% of body surface area of infants and children, or part thereof (List separately in addition to code for primary procedure)	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0481U	IDH1 (isocitrate dehydrogenase 1 [NADP+]), IDH2 (isocitrate dehydrogenase 2 [NADP+]), and TERT (telomerase reverse transcriptase) promoter (eg, central nervous system [CNS] tumors), next-generation sequencing (single-nucleotide variants [SNV], deletions, and insertions)	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
0482U	Obstetrics (preeclampsia), biochemical assay of soluble fms-like tyrosine kinase 1 (sFlt-1) and placental growth factor (PlGF), serum, ratio reported for sFlt-1/PlGF, with risk of progression for preeclampsia with severe features within 2 weeks	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0483T	Transcatheter mitral valve implantation/replacement (TMVI) with prosthetic valve; percutaneous approach, including transseptal puncture, when performed	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity and procedure report.
0484T	Transcatheter mitral valve implantation/replacement (TMVI) with prosthetic valve; transthoracic exposure (eg, thoracotomy, transapical)	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity and procedure report.
0485T	Optical coherence tomography (OCT) of middle ear, with interpretation and report; unilateral	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0485U	Oncology (solid tumor), cell-free DNA and RNA by next-generation sequencing, interpretative report for germline mutations, clonal hematopoiesis of indeterminate potential, and tumor-derived single-nucleotide variants, small insertions/deletions, copy number alterations, fusions, microsatellite instability, and tumor mutational burden	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
0486T	Optical coherence tomography (OCT) of middle ear, with interpretation and report; bilateral	Possible Denial; Medical Records Optional	Investigative	Documentation optional.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
0486U	Oncology (pan-solid tumor), next-generation sequencing analysis of tumor methylation markers present in cell-free circulating tumor DNA, algorithm reported as quantitative measurement of methylation as a correlate of tumor fraction	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
0487U	Oncology (solid tumor), cell-free circulating DNA, targeted genomic sequence analysis panel of 84 genes, interrogation for sequence variants, aneuploidy-corrected gene copy number amplifications and losses, gene rearrangements, and microsatellite instability	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
0488U	Obstetrics (fetal antigen noninvasive prenatal test), cell-free DNA sequence analysis for detection of fetal presence or absence of 1 or more of the Rh, C, c, D, E, Duffy (Fya), or Kell (K) antigen in alloimmunized pregnancies, reported as selected antigen(s) detected or not detected	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
0489T	Autologous adipose-derived regenerative cell therapy for scleroderma in the hands; adipose tissue harvesting, isolation and preparation of harvested cells including incubation with cell dissociation enzymes, removal of non-viable cells and debris, determination of concentration and dilution of regenerative cells	Possible Denial; Medical Records Optional	Investigative	Documentation optional.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
0489U	Obstetrics (single-gene noninvasive prenatal test), cell-free DNA sequence analysis of 1 or more targets (eg, CFTR, SMN1, HBB, HBA1, HBA2) to identify paternally inherited pathogenic variants, and relative mutation-dosage analysis based on molecular counts to determine fetal inheritance of maternal mutation, algorithm reported as a fetal risk score for the condition (eg, cystic fibrosis, spinal muscular atrophy, beta hemoglobinopathies [including sickle cell disease], alpha thalassemia)	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
0490T	Autologous adipose-derived regenerative cell therapy for scleroderma in the hands; multiple injections in one or both hands	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0490U	Oncology (cutaneous or uveal melanoma), circulating tumor cell selection, morphological characterization and enumeration based on differential CD146, high molecular-weight melanoma-associated antigen, CD34 and CD45 protein biomarkers, peripheral blood	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0491U	Oncology (solid tumor), circulating tumor cell selection, morphological characterization and enumeration based on differential epithelial cell adhesion molecule (EpCAM), cytokeratins 8, 18, and 19, CD45 protein biomarkers, and quantification of estrogen receptor (ER) protein biomarker-expressing cells, peripheral blood	Possible Denial; Medical Records Optional	Investigative	Documentation optional.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
0492U	Oncology (solid tumor), circulating tumor cell selection, morphological characterization and enumeration based on differential epithelial cell adhesion molecule (EpCAM), cytokeratins 8, 18, and 19, CD45 protein biomarkers, and quantification of PD-L1 protein biomarker-expressing cells, peripheral blood	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0493U	Transplantation medicine, quantification of donor-derived cell-free DNA (cfDNA) using next-generation sequencing, plasma, reported as percentage of donor-derived cell-free DNA	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
0494U	Red blood cell antigen (fetal RhD gene analysis), next-generation sequencing of circulating cell-free DNA (cfDNA) of blood in pregnant individuals known to be RhD negative, reported as positive or negative	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
0495U	Oncology (prostate), analysis of circulating plasma proteins (tPSA, fPSA, KLK2, PSP94, and GDF15), germline polygenic risk score (60 variants), clinical information (age, family history of prostate cancer, prior negative prostate biopsy), algorithm reported as risk of likelihood of detecting clinically significant prostate cancer	Possible Denial; Medical Records Optional	Investigative	Documentation optional.

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0496U	Oncology (colorectal), cell-free DNA, 8 genes for mutations, 7 genes for methylation by real-time RT-PCR, and 4 proteins by enzyme-linked immunosorbent assay, blood, reported positive or negative for colorectal cancer or advanced adenoma risk	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
0497U	Oncology (prostate), mRNA gene-expression profiling by real-time RT-PCR of 6 genes (FOXM1, MCM3, MTUS1, TTC21B, ALAS1, and PPP2CA), utilizing formalin-fixed paraffin-embedded (FFPE) tissue, algorithm reported as a risk score for prostate cancer	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
0498U	Oncology (colorectal), next-generation sequencing for mutation detection in 43 genes and methylation pattern in 45 genes, blood, and formalin-fixed paraffin-embedded (FFPE) tissue, report of variants and methylation pattern with interpretation	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
0499U	Oncology (colorectal and lung), DNA from formalin-fixed paraffin-embedded (FFPE) tissue, next-generation sequencing of 8 genes (NRAS, EGFR, CTNNB1, PIK3CA, APC, BRAF, KRAS, and TP53), mutation detection	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
0500U	Autoinflammatory disease (VEXAS syndrome), DNA, UBA1 gene mutations, targeted variant analysis (M41T, M41V, M41L, c.118-2A>C, c.118-1G>C, c.118-9_118-2del, S56F, S621C)	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.

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0501U	Oncology (colorectal), blood, quantitative measurement of cell-free DNA (cfDNA)	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0503U	Neurology (Alzheimer disease), beta amyloid (AB40, AB42, AB42/40 ratio) and tau-protein (ptau217, np-tau217, ptau217/np-tau217 ratio), blood, immunoprecipitation with quantitation by liquid chromatography with tandem mass spectrometry (LC-MS/MS), algorithm score reported as likelihood of positive or negative for amyloid plaques	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0505T	Endovenous femoral-popliteal arterial revascularization, with transcatheter placement of intravascular stent graft(s) and closure by any method, including percutaneous or open vascular access, ultrasound guidance for vascular access when performed, all catheterization(s) and intraprocedural roadmapping and imaging guidance necessary to complete the intervention, all associated radiological supervision and interpretation, when performed, with crossing of the occlusive lesion in an extraluminal fashion	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity and procedure report.
0505U	Infectious disease (vaginal infection), identification of 32 pathogenic organisms, swab, real-time PCR, reported as positive or negative for each organism	Possible Denial; Medical Records Optional	Investigative	Documentation optional.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
0506U	Gastroenterology (Barrett's esophagus), esophageal cells, DNA methylation analysis by next-generation sequencing of at least 89 differentially methylated genomic regions, algorithm reported as likelihood for Barrett's esophagus	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
0507U	Oncology (ovarian), DNA, whole-genome sequencing with 5-hydroxymethylcytosine (5hmC) enrichment, using whole blood or plasma, algorithm reported as cancer detected or not detected	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
0508U	Transplantation medicine, quantification of donor-derived cell-free DNA using 40 single-nucleotide polymorphisms (SNPs), plasma, and urine, initial evaluation reported as percentage of donor-derived cell-free DNA with risk for active rejection	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
0509U	Transplantation medicine, quantification of donor-derived cell-free DNA using up to 12 single-nucleotide polymorphisms (SNPs) previously identified, plasma, reported as percentage of donor-derived cell-free DNA with risk for active rejection	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
0510T	Removal of sinus tarsi implant	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0510U	Oncology (pancreatic cancer), augmentative algorithmic analysis of 16 genes from previously sequenced RNA whole-transcriptome data, reported as probability of predicted molecular subtype	Possible Denial; Medical Records Optional	Investigative	Documentation optional.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
0511T	Removal and reinsertion of sinus tarsi implant	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0511U	Oncology (solid tumor), tumor cell culture in 3D microenvironment, 36 or more drug panel, reported as tumor-response prediction for each drug	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0512U	Oncology (prostate), augmentative algorithmic analysis of digitized whole-slide imaging of histologic features for microsatellite instability (MSI) status, formalin-fixed paraffin-embedded (FFPE) tissue, reported as increased or decreased probability of MSI-high (MSI-H)	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0513U	Oncology (prostate), augmentative algorithmic analysis of digitized whole-slide imaging of histologic features for microsatellite instability (MSI) and homologous recombination deficiency (HRD) status, formalin-fixed paraffin-embedded (FFPE) tissue, reported as increased or decreased probability of each biomarker	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0516U	Drug metabolism, whole blood, pharmacogenomic genotyping of 40 genes and CYP2D6 copy number variant analysis, reported as metabolizer status	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
0517U	Therapeutic drug monitoring, 80 or more psychoactive drugs or substances, LC-MS/MS, plasma, qualitative and quantitative therapeutic minimally and maximally effective dose of prescribed and non-prescribed medications	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
0518U	Therapeutic drug monitoring, 90 or more pain and mental health drugs or substances, LC-MS/MS, plasma, qualitative and quantitative therapeutic minimally effective range of prescribed and non-prescribed medications	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
0519U	Therapeutic drug monitoring, medications specific to pain, depression, and anxiety, LC-MS/MS, plasma, 110 or more drugs or substances, qualitative and quantitative therapeutic minimally effective range of prescribed, non-prescribed, and illicit medications in circulation	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
0520U	Therapeutic drug monitoring, 200 or more drugs or substances, LC-MS/MS, plasma, qualitative and quantitative therapeutic minimally effective range of prescribed and non-prescribed medications	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
0521U	Rheumatoid factor IgA and IgM, cyclic citrullinated peptide (CCP) antibodies, and scavenger receptor A (SR-A) by immunoassay, blood	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0522U	Carbonic anhydrase VI, parotid specific/secretory protein and salivary protein 1 (SP1), IgG, IgM, and IgA antibodies, chemiluminescence, semiqualitative, blood	Possible Denial; Medical Records Optional	Investigative	Documentation optional.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
0523U	Oncology (solid tumor), DNA, qualitative, next-generation sequencing (NGS) of single-nucleotide variants (SNV) and insertion/deletions in 22 genes utilizing formalin-fixed paraffin-embedded tissue, reported as presence or absence of mutation(s), location of mutation(s), nucleotide change, and amino acid change	Prior Authorization Required	Genetic Testing	No review for non-cancer diagnoses. FOR CANCER DIAGNOSES ONLY: Submit online review with Carelon at www.providerportal.com. For prior authorization include history and physical, results of previous diagnostics procedure report.
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 Required	Medical Necessity	Submit history and physical, documentation of medical necessity and procedure report.
0524U	Obstetrics (preeclampsia), sFlt-1/PlGF ratio, immunoassay, utilizing serum or plasma, reported as a value	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0525U	Oncology, spheroid cell culture, 11-drug panel (carboplatin, docetaxel, doxorubicin, etoposide, gemcitabine, niraparib, olaparib, paclitaxel, rucaparib, topotecan, veliparib) ovarian, fallopian, or peritoneal response prediction for each drug	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0526U	Nephrology (renal transplant), quantification of CXCL10 chemokines, flow cytometry, urine, reported as pg/mL creatinine baseline and monitoring over time	Possible Denial; Medical Records Optional	Investigative	Documentation optional.

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0528U	Lower respiratory tract infectious agent detection, 18 bacteria, 8 viruses, and 7 antimicrobial-resistance genes, amplified probe technique, including reverse transcription for RNA targets, each analyte reported as detected or not detected with semiquantitative results for 15 bacteria	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0529U	Hematology (venous thromboembolism [VTE]), genome-wide single-nucleotide polymorphism variants, including F2 and F5 gene analysis, and Leiden variant, by microarray analysis, saliva, report as risk score for VTE	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
0530U	Oncology (pan-solid tumor), ctDNA, utilizing plasma, next-generation sequencing (NGS) of 77 genes, 8 fusions, microsatellite instability, and tumor mutation burden, interpretative report for single-nucleotide variants, copy-number alterations, with therapy association	Prior Authorization Required	Genetic Testing	No review for non-cancer diagnoses. FOR CANCER DIAGNOSES ONLY: Submit online review with Carelon at www.providerportal.com. For prior authorization include history and physical, results of previous diagnostics procedure report.
0531U	Infectious disease (acid-fast bacteria and invasive fungi), DNA (673 organisms), next-generation sequencing, plasma	Possible Denial; Medical Records Optional	Medical Necessity	Documentation optional.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
0532U	Rare diseases (constitutional disease/hereditary disorders), rapid whole genome and mitochondrial DNA sequencing for single-nucleotide variants, insertions/deletions, copy number variations, peripheral blood, buffy coat, saliva, buccal or tissue sample, results reported as positive or negative	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
0533U	Drug metabolism (adverse drug reactions and drug response), genotyping of 16 genes (ie, ABCG2, CYP2B6, CYP2C9, CYP2C19, CYP2C, CYP2D6, CYP3A5, CYP4F2, DPYD, G6PD, GGCX, NUDT15, SLCO1B1, TPMT, UGT1A1, VKORC1), reported as metabolizer status and transporter function	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
0534U	Oncology (prostate), microRNA, single-nucleotide polymorphisms (SNPs) analysis by RT-PCR of 32 variants, using buccal swab, algorithm reported as a risk score	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
0535U	Perfluoroalkyl substances (PFAS) (eg, perfluorooctanoic acid, perfluorooctane sulfonic acid), by liquid chromatography with tandem mass spectrometry (LC-MS/MS), plasma or serum, quantitative	Possible Denial; Medical Records Optional	Medical Necessity	Documentation optional.
0536U	Red blood cell antigen (fetal RhD), PCR analysis of exon 4 of RHD gene and housekeeping control gene GAPDH from whole blood in pregnant individuals at 10+ weeks gestation known to be RhD negative, reported as fetal RhD status	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
0537U	Oncology (colorectal cancer), analysis of cell-free DNA for epigenomic patterns, next-generation sequencing, >2500 differentially methylated regions (DMRs), plasma, algorithm reported as positive or negative	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
0538U	Oncology (solid tumor), next-generation targeted sequencing analysis, formalin-fixed paraffin-embedded (FFPE) tumor tissue, DNA analysis of 600 genes, interrogation for single-nucleotide variants, insertions/deletions, gene rearrangements, and copy number alterations, microsatellite instability, tumor mutation burden, reported as actionable variant	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
0539U	Oncology (solid tumor), cell-free circulating tumor DNA (ctDNA), 152 genes, next-generation sequencing, interrogation for single-nucleotide variants, insertions/deletions, gene rearrangements, copy number alterations, and microsatellite instability, using whole-blood samples, mutations with clinical actionability reported as actionable variant	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
0540U	Transplantation medicine, quantification of donor-derived cell-free DNA using next-generation sequencing analysis of plasma, reported as percentage of donor-derived cell-free DNA to determine probability of rejection	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
0541U	Cardiovascular disease (HDL reverse cholesterol transport), cholesterol efflux capacity, LC-MS/MS, quantitative measurement of 5 distinct HDL-bound apolipoproteins (apolipoproteins A1, C1, C2, C3, and C4), serum, algorithm reported as prediction of coronary artery disease (pCAD) score	Possible Denial; Medical Records Optional	Medical Necessity	Documentation optional.
0543U	Oncology (solid tumor), next-generation sequencing of DNA from formalin-fixed paraffin-embedded (FFPE) tissue of 517 genes, interrogation for single-nucleotide variants, multi-nucleotide variants, insertions and deletions from DNA, fusions in 24 genes and splice variants in 1 gene from RNA, and tumor mutation burden	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
0544T	Transcatheter mitral valve annulus reconstruction, with implantation of adjustable annulus reconstruction device, percutaneous approach including transseptal puncture	Prior Authorization Required	Medical Necessity	Submit History and Physical, documentation of medical necessity, operative report
0544U	Nephrology (transplant monitoring), 48 variants by digital PCR, using cell-free DNA from plasma, donor-derived cell-free DNA, percentage reported as risk for rejection	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
0546U	Low-density lipoprotein receptor-related protein 4 (LRP4), antibody identification by immunofluorescence, using live cells, reported as positive or negative	Possible Denial; Medical Records Optional	Medical Necessity	Documentation optional.
0547U	Neurofilament light chain (NfL), chemiluminescent enzyme immunoassay, plasma, quantitative	Possible Denial; Medical Records Optional	Medical Necessity	Documentation optional.

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0548U	Glial fibrillary acidic protein (GFAP), chemiluminescent enzyme immunoassay, using plasma	Possible Denial; Medical Records Optional	Medical Necessity	Documentation optional.
0549U	Oncology (urothelial), DNA, quantitative methylated real-time PCR of TRNA-Cys, SIM2, and NKX1-1, using urine, diagnostic algorithm reported as a probability index for bladder cancer and/or upper tract urothelial carcinoma (UTUC)	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
0550U	Oncology (prostate), enzyme-linked immunosorbent assays (ELISA) for total prostate-specific antigen (PSA) and free PSA, serum, combined with age, previous negative prostate biopsy status, digital rectal examination findings, prostate volume, and image and data reporting of the prostate, algorithm reported as a risk score for the presence of high-grade prostate cancer	Possible Denial; Medical Records Optional	Medical Necessity	Documentation optional.
0551U	Tau, phosphorylated, pTau217, by single-molecule array (ultrasensitive digital protein detection), using plasma	Possible Denial; Medical Records Optional	Medical Necessity	Documentation optional.
0552T	Low-level laser therapy, dynamic photonic and dynamic thermokinetic energies, provided by a physician or other qualified health care professional	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
0561T	Anatomic guide 3D-printed and designed from image data set(s); first anatomic guide	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0562T	Anatomic guide 3D-printed and designed from image data set(s); each additional anatomic guide (List separately in addition to code for primary procedure)	Possible Denial; Medical Records Optional	Investigative	Documentation optional.

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0565T	Autologous cellular implant derived from adipose tissue for the treatment of osteoarthritis of the knees; tissue harvesting and cellular implant creation	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0566T	Autologous cellular implant derived from adipose tissue for the treatment of osteoarthritis of the knees; injection of cellular implant into knee joint including ultrasound guidance, unilateral	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0581T	Ablation, malignant breast tumor(s), percutaneous, cryotherapy, including imaging guidance when performed, unilateral	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0582T	Transurethral ablation of malignant prostate tissue by high-energy water vapor thermotherapy, including intraoperative imaging and needle guidance	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0584T	Islet cell transplant, includes portal vein catheterization and infusion, including all imaging, including guidance, and radiological supervision and interpretation, when performed; percutaneous	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity and procedure report.
0585T	Islet cell transplant, includes portal vein catheterization and infusion, including all imaging, including guidance, and radiological supervision and interpretation, when performed; laparoscopic	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity and procedure report.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
0586T	Islet cell transplant, includes portal vein catheterization and infusion, including all imaging, including guidance, and radiological supervision and interpretation, when performed; open	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity and procedure report.
0594T	Osteotomy, humerus, with insertion of an externally controlled intramedullary lengthening device, including intraoperative imaging, initial and subsequent alignment assessments, computations of adjustment schedules, and management of the intramedullary lengthening device	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0596T	Temporary female intraurethral valve-pump (ie, voiding prosthesis); initial insertion, including urethral measurement	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0597T	Temporary female intraurethral valve-pump (ie, voiding prosthesis); replacement	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0598T	Noncontact real-time fluorescence wound imaging, for bacterial presence, location, and load, per session; first anatomic site (eg, lower extremity)	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0599T	Noncontact real-time fluorescence wound imaging, for bacterial presence, location, and load, per session; each additional anatomic site (eg, upper extremity) (List separately in addition to code for primary procedure)	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0600T	Ablation, irreversible electroporation; 1 or more tumors per organ, including imaging guidance, when performed, percutaneous	Possible Denial; Medical Records Optional	Investigative	Documentation optional.

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0601T	Ablation, irreversible electroporation; 1 or more tumors, including fluoroscopic and ultrasound guidance, when performed, open	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0602T	Glomerular filtration rate (GFR) measurement(s), transdermal, including sensor placement and administration of a single dose of fluorescent pyrazine agent	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0603T	Glomerular filtration rate (GFR) monitoring, transdermal, including sensor placement and administration of more than one dose of fluorescent pyrazine agent, each 24 hours	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0604T	Optical coherence tomography (OCT) of retina, remote, patient-initiated image capture and transmission to a remote surveillance center unilateral or bilateral; initial device provision, set-up and patient education on use of equipment	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0605T	Optical coherence tomography (OCT) of retina, remote, patient-initiated image capture and transmission to a remote surveillance center unilateral or bilateral; remote surveillance center technical support, data analyses and reports, with a minimum of 8 daily recordings, each 30 days	Possible Denial; Medical Records Optional	Investigative	Documentation optional.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
0606T	Optical coherence tomography (OCT) of retina, remote, patient-initiated image capture and transmission to a remote surveillance center unilateral or bilateral; review, interpretation and report by the prescribing physician or other qualified health care professional of remote surveillance center data analyses, each 30 days	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0607T	Remote monitoring of an external continuous pulmonary fluid monitoring system, including measurement of radiofrequency-derived pulmonary fluid levels, heart rate, respiration rate, activity, posture, and cardiovascular rhythm (eg, ECG data), transmitted to a remote 24-hour attended surveillance center; set-up and patient education on use of equipment	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0608T	Remote monitoring of an external continuous pulmonary fluid monitoring system, including measurement of radiofrequency-derived pulmonary fluid levels, heart rate, respiration rate, activity, posture, and cardiovascular rhythm (eg, ECG data), transmitted to a remote 24-hour attended surveillance center; analysis of data received and transmission of reports to the physician or other qualified health care professional	Possible Denial; Medical Records Optional	Investigative	Documentation optional.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
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	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0610T	Magnetic resonance spectroscopy, determination and localization of discogenic pain (cervical, thoracic, or lumbar); transmission of biomarker data for software analysis	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
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	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0612T	Magnetic resonance spectroscopy, determination and localization of discogenic pain (cervical, thoracic, or lumbar); interpretation and report	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0613T	Percutaneous transcatheter implantation of interatrial septal shunt device, including right and left heart catheterization, intracardiac echocardiography, and imaging guidance by the proceduralist, when performed	Possible Denial; Medical Records Optional	Investigative	Documentation optional.

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0615T	Automated analysis of binocular eye movements without spatial calibration, including disconjugacy, saccades, and pupillary dynamics for the assessment of concussion, with interpretation and report	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0619T	Cystourethroscopy with transurethral anterior prostate commissurotomy and drug delivery, including transrectal ultrasound and fluoroscopy, when performed	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0620T	Endovascular venous arterialization, tibial or peroneal vein, with transcatheter placement of intravascular stent graft(s) and closure by any method, including percutaneous or open vascular access, ultrasound guidance for vascular access when performed, all catheterization(s) and intraprocedural roadmapping and imaging guidance necessary to complete the intervention, all associated radiological supervision and interpretation, when performed	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0621T	Trabeculostomy ab interno by laser	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0622T	Trabeculostomy ab interno by laser; with use of ophthalmic endoscope	Possible Denial; Medical Records Optional	Investigative	Documentation optional.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
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	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
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	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
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	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
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	Possible Denial; Medical Records Optional	Investigative	Documentation optional.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
0631T	Transcutaneous visible light hyperspectral imaging measurement of oxyhemoglobin, deoxyhemoglobin, and tissue oxygenation, with interpretation and report, per extremity	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0632T	Percutaneous transcatheter ultrasound ablation of nerves innervating the pulmonary arteries, including right heart catheterization, pulmonary artery angiography, and all imaging guidance	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0633T	Computed tomography, breast, including 3D rendering, when performed, unilateral; without contrast material	Prior Authorization Required	Advanced Imaging	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
0634T	Computed tomography, breast, including 3D rendering, when performed, unilateral; with contrast material(s)	Prior Authorization Required	Advanced Imaging	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
0635T	Computed tomography, breast, including 3D rendering, when performed, unilateral; without contrast, followed by contrast material(s)	Prior Authorization Required	Advanced Imaging	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
0636T	Computed tomography, breast, including 3D rendering, when performed, bilateral; without contrast material(s)	Prior Authorization Required	Advanced Imaging	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
0637T	Computed tomography, breast, including 3D rendering, when performed, bilateral; with contrast material(s)	Prior Authorization Required	Advanced Imaging	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
0638T	Computed tomography, breast, including 3D rendering, when performed, bilateral; without contrast, followed by contrast material(s)	Prior Authorization Required	Advanced Imaging	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
0639T	Wireless skin sensor thermal anisotropy measurement(s) and assessment of flow in cerebrospinal fluid shunt, including ultrasound guidance, when performed	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0648T	Quantitative magnetic resonance for analysis of tissue composition (eg, fat, iron, water content), including multiparametric data acquisition, data preparation and transmission, interpretation and report, obtained without diagnostic MRI examination of the same anatomy (eg, organ, gland, tissue, target structure) during the same session; single organ	Prior Authorization Required	Advanced Imaging	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.

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0649T	Quantitative magnetic resonance for analysis of tissue composition (eg, fat, iron, water content), including multiparametric data acquisition, data preparation and transmission, interpretation and report, obtained with diagnostic MRI examination of the same anatomy (eg, organ, gland, tissue, target structure); single organ (List separately in addition to code for primary procedure)	Prior Authorization Required	Advanced Imaging	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
0655T	Transperineal focal laser ablation of malignant prostate tissue, including transrectal imaging guidance with mr-fused images or other enhanced ultrasound imaging	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0662T	Scalp cooling, mechanical; initial measurement and calibration of cap	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
0663T	Scalp cooling, mechanical; placement of device monitoring and removal of device	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
0664T	Donor hysterectomy (including cold preservation); open, from cadaver donor	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0665T	Donor hysterectomy (including cold preservation); open, from living donor	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0666T	Donor hysterectomy (including cold preservation); laparoscopic or robotic, from living donor	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0667T	Donor hysterectomy (including cold preservation); recipient uterus allograft transplantation from cadaver or living donor	Possible Denial; Medical Records Optional	Investigative	Documentation optional.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
0668T	Backbench standard preparation of cadaver or living donor uterine allograft prior to transplantation, including dissection and removal of surrounding soft tissues and preparation of uterine vein(s) and uterine artery(ies), as necessary	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0669T	Backbench reconstruction of cadaver or living donor uterus allograft prior to transplantation; venous anastomosis, each	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0670T	Backbench reconstruction of cadaver or living donor uterus allograft prior to transplantation; arterial anastomosis, each	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0672T	Endovaginal cryogen-cooled, monopolar radiofrequency remodeling of the tissues surrounding the female bladder neck and proximal urethra for urinary incontinence	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0673T	Ablation, benign thyroid nodule(s), percutaneous, laser, including imaging guidance	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0674T	Laparoscopic insertion of new or replacement of permanent implantable synchronized diaphragmatic stimulation system for augmentation of cardiac function, including an implantable pulse generator and diaphragmatic lead(s)	Possible Denial; Medical Records Optional	Investigative	Documentation optional.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
0675T	Laparoscopic insertion of new or replacement of diaphragmatic lead(s), permanent implantable synchronized diaphragmatic stimulation system for augmentation of cardiac function, including connection to an existing pulse generator; first lead	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0676T	Laparoscopic insertion of new or replacement of diaphragmatic lead(s), permanent implantable synchronized diaphragmatic stimulation system for augmentation of cardiac function, including connection to an existing pulse generator; each additional lead (List separately in addition to code for primary procedure)	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0677T	Laparoscopic repositioning of diaphragmatic lead(s), permanent implantable synchronized diaphragmatic stimulation system for augmentation of cardiac function, including connection to an existing pulse generator; first repositioned lead	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0678T	Laparoscopic repositioning of diaphragmatic lead(s), permanent implantable synchronized diaphragmatic stimulation system for augmentation of cardiac function, including connection to an existing pulse generator; each additional repositioned lead (List separately in addition to code for primary procedure)	Possible Denial; Medical Records Optional	Investigative	Documentation optional.

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0679T	Laparoscopic removal of diaphragmatic lead(s), permanent implantable synchronized diaphragmatic stimulation system for augmentation of cardiac function	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0680T	Insertion or replacement of pulse generator only, permanent implantable synchronized diaphragmatic stimulation system for augmentation of cardiac function, with connection to existing lead(s)	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0681T	Relocation of pulse generator only, permanent implantable synchronized diaphragmatic stimulation system for augmentation of cardiac function, with connection to existing dual leads	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0682T	Removal of pulse generator only, permanent implantable synchronized diaphragmatic stimulation system for augmentation of cardiac function	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0683T	Programming device evaluation (in-person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, review and report by a physician or other qualified health care professional, permanent implantable synchronized diaphragmatic stimulation system for augmentation of cardiac function	Possible Denial; Medical Records Optional	Investigative	Documentation optional.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
0684T	Peri-procedural device evaluation (in-person) and programming of device system parameters before or after a surgery, procedure, or test with analysis, review, and report by a physician or other qualified health care professional, permanent implantable synchronized diaphragmatic stimulation system for augmentation of cardiac function	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0685T	Interrogation device evaluation (in-person) with analysis, review and report by a physician or other qualified health care professional, including connection, recording and disconnection per patient encounter, permanent implantable synchronized diaphragmatic stimulation system for augmentation of cardiac function	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0686T	Histotripsy (ie, non-thermal ablation via acoustic energy delivery) of malignant hepatocellular tissue, including image guidance	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0687T	Treatment of amblyopia using an online digital program; device supply, educational set-up, and initial session	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0688T	Treatment of amblyopia using an online digital program; assessment of patient performance and program data by physician or other qualified health care professional, with report, per calendar month	Possible Denial; Medical Records Optional	Investigative	Documentation optional.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
0689T	Quantitative ultrasound tissue characterization (non-elastographic), including interpretation and report, obtained without diagnostic ultrasound examination of the same anatomy (eg, organ, gland, tissue, target structure)	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0690T	Quantitative ultrasound tissue characterization (non-elastographic), including interpretation and report, obtained with diagnostic ultrasound examination of the same anatomy (eg, organ, gland, tissue, target structure) (List separately in addition to code for primary procedure)	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0691T	Automated analysis of an existing computed tomography study for vertebral fracture(s), including assessment of bone density when performed, data preparation, interpretation, and report	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0692T	Therapeutic ultrafiltration	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0693T	Comprehensive full body computer-based markerless 3D kinematic and kinetic motion analysis and report	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0694T	3-dimensional volumetric imaging and reconstruction of breast or axillary lymph node tissue, each excised specimen, 3-dimensional automatic specimen reorientation, interpretation and report, real-time intraoperative	Possible Denial; Medical Records Optional	Investigative	Documentation optional.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
0695T	Body surface-activation mapping of pacemaker or pacing cardioverter-defibrillator lead(s) to optimize electrical synchrony, cardiac resynchronization therapy device, including connection, recording, disconnection, review, and report; at time of implant or replacement	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0696T	Body surface-activation mapping of pacemaker or pacing cardioverter-defibrillator lead(s) to optimize electrical synchrony, cardiac resynchronization therapy device, including connection, recording, disconnection, review, and report; at time of follow-up interrogation or programming device evaluation	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
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 without diagnostic MRI examination of the same anatomy (eg, organ, gland, tissue, target structure) during the same session; multiple organs	Possible Denial; Medical Records Optional	Investigative	Documentation optional.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
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)	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0700T	Molecular fluorescent imaging of suspicious nevus; first lesion	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0701T	Molecular fluorescent imaging of suspicious nevus; each additional lesion (List separately in addition to code for primary procedure)	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0704T	Remote treatment of amblyopia using an eye tracking device; device supply with initial set-up and patient education on use of equipment	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0705T	Remote treatment of amblyopia using an eye tracking device; surveillance center technical support including data transmission with analysis, with a minimum of 18 training hours, each 30 days	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0706T	Remote treatment of amblyopia using an eye tracking device; interpretation and report by physician or other qualified health care professional, per calendar month	Possible Denial; Medical Records Optional	Investigative	Documentation optional.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
0707T	Injection(s), bone-substitute material (eg, calcium phosphate) into subchondral bone defect (ie, bone marrow lesion, bone bruise, stress injury, microtrabecular fracture), including imaging guidance and arthroscopic assistance for joint visualization	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0708T	Intradermal cancer immunotherapy; preparation and initial injection	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0709T	Intradermal cancer immunotherapy; each additional injection (List separately in addition to code for primary procedure)	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
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	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0711T	Noninvasive arterial plaque analysis using software processing of data from non-coronary computerized tomography angiography; data preparation and transmission	Possible Denial; Medical Records Optional	Investigative	Documentation optional.

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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	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0713T	Noninvasive arterial plaque analysis using software processing of data from non-coronary computerized tomography angiography; data review, interpretation and report	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0720T	Percutaneous electrical nerve field stimulation, cranial nerves, without implantation	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0721T	Quantitative computed tomography (CT) tissue characterization, including interpretation and report, obtained without concurrent CT examination of any structure contained in previously acquired diagnostic imaging	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0722T	Quantitative computed tomography (CT) tissue characterization, including interpretation and report, obtained with concurrent CT examination of any structure contained in the concurrently acquired diagnostic imaging dataset (List separately in addition to code for primary procedure)	Possible Denial; Medical Records Optional	Investigative	Documentation optional.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
0723T	Quantitative magnetic resonance cholangiopancreatography (QMRCP) including data preparation and transmission, interpretation and report, obtained without diagnostic magnetic resonance imaging (MRI) examination of the same anatomy (eg, organ, gland, tissue, target structure) during the same session	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0724T	Quantitative magnetic resonance cholangiopancreatography (QMRCP) including data preparation and transmission, interpretation and report, obtained with diagnostic magnetic resonance imaging (MRI) examination of the same anatomy (eg, organ, gland, tissue, target structure) (List separately in addition to code for primary procedure)	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0731T	Augmentative AI-based facial phenotype analysis with report	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0732T	Immunotherapy administration with electroporation, intramuscular	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0733T	Remote real-time, motion capture-based neurorehabilitative therapy ordered by a physician or other qualified health care professional; supply and technical support, per 30 days	Possible Denial; Medical Records Optional	Investigative	Documentation optional.

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0734T	Remote body and limb kinematic measurement-based therapy ordered by a physician or other qualified health care professional; treatment management services by a physician or other qualified health care professional, per calendar month	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0736T	Colonic lavage, 35 or more liters of water, gravity-fed, with induced defecation, including insertion of rectal catheter	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0737T	Xenograft implantation into the articular surface	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0738T	Treatment planning for magnetic field induction ablation of malignant prostate tissue, using data from previously performed magnetic resonance imaging (MRI) examination	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0739T	Ablation of malignant prostate tissue by magnetic field induction, including all intraprocedural, transperineal needle/catheter placement for nanoparticle installation and intraprocedural temperature monitoring, thermal dosimetry, bladder irrigation, and magnetic field nanoparticle activation	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0740T	Remote autonomous algorithm-based recommendation system for insulin dose calculation and titration; initial set-up and patient education	Possible Denial; Medical Records Optional	Investigative	Documentation optional.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
0741T	Remote autonomous algorithm-based recommendation system for insulin dose calculation and titration; provision of software, data collection, transmission, and storage, each 30 days	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0743T	Bone strength and fracture risk using finite element analysis of functional data and bone mineral density (BMD), with concurrent vertebral fracture assessment, utilizing data from a computed tomography scan, retrieval and transmission of the scan data, measurement of bone strength and BMD and classification of any vertebral fractures, with overall fracture-risk assessment, interpretation and report	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0744T	Insertion of bioprosthetic valve, open, femoral vein, including duplex ultrasound imaging guidance, when performed, including autogenous or nonautogenous patch graft (eg, polyester, ePTFE, bovine pericardium), when performed	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0745T	Cardiac focal ablation utilizing radiation therapy for arrhythmia; noninvasive arrhythmia localization and mapping of arrhythmia site (nidus), derived from anatomical image data (eg, CT, MRI, or myocardial perfusion scan) and electrical data (eg, 12-lead ECG data), and identification of areas of avoidance	Possible Denial; Medical Records Optional	Investigative	Documentation optional.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
0746T	Cardiac focal ablation utilizing radiation therapy for arrhythmia; conversion of arrhythmia localization and mapping of arrhythmia site (nidus) into a multidimensional radiation treatment plan	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0747T	Cardiac focal ablation utilizing radiation therapy for arrhythmia; delivery of radiation therapy, arrhythmia	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0748T	Injections of stem cell product into perianal perifistular soft tissue, including fistula preparation (eg, removal of setons, fistula curettage, closure of internal openings)	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0749T	Bone strength and fracture-risk assessment using digital X-ray radiogrammetry-bone mineral density (DXR-BMD) analysis of bone mineral density (BMD) utilizing data from a digital X ray, retrieval and transmission of digital X-ray data, assessment of bone strength and fracture risk and BMD, interpretation and report;	Possible Denial; Medical Records Optional	Investigative	Documentation optional.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
0750T	Bone strength and fracture-risk assessment using digital X-ray radiogrammetry-bone mineral density (DXR-BMD) analysis of bone mineral density (BMD) utilizing data from a digital X ray, retrieval and transmission of digital X-ray data, assessment of bone strength and fracture risk and BMD, interpretation and report; with single-view digital X-ray examination of the hand taken for the purpose of DXR-BMD	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0753T	Digitization of glass microscope slides for level IV, surgical pathology, gross and microscopic examination (List separately in addition to code for primary procedure)	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
0756T	Digitization of glass microscope slides for special stain, including interpretation and report, group I, for microorganisms (eg, acid fast, methenamine silver) (List separately in addition to code for primary procedure)	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
0764T	Assistive algorithmic electrocardiogram risk-based assessment for cardiac dysfunction (eg, low-ejection fraction, pulmonary hypertension, hypertrophic cardiomyopathy); related to concurrently performed electrocardiogram (List separately in addition to code for primary procedure)	Possible Denial; Medical Records Optional	Investigative	Documentation optional.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
0765T	Assistive algorithmic electrocardiogram risk-based assessment for cardiac dysfunction (eg, low-ejection fraction, pulmonary hypertension, hypertrophic cardiomyopathy); related to previously performed electrocardiogram	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0766T	Transcutaneous magnetic stimulation by focused low-frequency electromagnetic pulse, peripheral nerve, with identification and marking of the treatment location, including noninvasive electroneurographic localization (nerve conduction localization), when performed; first nerve	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0767T	Transcutaneous magnetic stimulation by focused low-frequency electromagnetic pulse, peripheral nerve, initial treatment, with identification and marking of the treatment location, including noninvasive electroneurographic localization (nerve conduction localization), when performed; each additional nerve (List separately in addition to code for primary procedure)	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0770T	Virtual reality technology to assist therapy (List separately in addition to code for primary procedure)	Possible Denial; Medical Records Optional	Investigative	Documentation optional.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
0771T	Virtual reality (VR) procedural dissociation services provided by the same physician or other qualified health care professional performing the diagnostic or therapeutic service that the VR procedural dissociation supports, requiring the presence of an independent, trained observer to assist in the monitoring of the patient's level of dissociation or consciousness and physiological status; initial 15 minutes of intraservice time, patient age 5 years or older	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0772T	Virtual reality (VR) procedural dissociation services provided by the same physician or other qualified health care professional performing the diagnostic or therapeutic service that the VR procedural dissociation supports, requiring the presence of an independent, trained observer to assist in the monitoring of the patient's level of dissociation or consciousness and physiological status; each additional 15 minutes intraservice time (List separately in addition to code for primary service)	Possible Denial; Medical Records Optional	Investigative	Documentation optional.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
0773T	Virtual reality (VR) procedural dissociation services provided by a physician or other qualified health care professional other than the physician or other qualified health care professional performing the diagnostic or therapeutic service that the VR procedural dissociation supports; initial 15 minutes of intraservice time, patient age 5 years or older	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0774T	Virtual reality (VR) procedural dissociation services provided by a physician or other qualified health care professional other than the physician or other qualified health care professional performing the diagnostic or therapeutic service that the VR procedural dissociation supports; each additional 15 minutes intraservice time (List separately in addition to code for primary service)	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0776T	Therapeutic induction of intra-brain hypothermia, including placement of a mechanical temperature-controlled cooling device to the neck over carotids and head, including monitoring (eg, vital signs and sport concussion assessment tool 5 [SCAT5]), 30 minutes of treatment	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0777T	Real-time pressure-sensing epidural guidance system (List separately in addition to code for primary procedure)	Possible Denial; Medical Records Optional	Investigative	Documentation optional.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
0778T	Surface mechanomyography (sMMG) with concurrent application of inertial measurement unit (IMU) sensors for measurement of multi-joint range of motion, posture, gait, and muscle function	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0781T	Bronchoscopy, rigid or flexible, with insertion of esophageal protection device and circumferential radiofrequency destruction of the pulmonary nerves, including fluoroscopic guidance when performed; bilateral mainstem bronchi	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0782T	Bronchoscopy, rigid or flexible, with insertion of esophageal protection device and circumferential radiofrequency destruction of the pulmonary nerves, including fluoroscopic guidance when performed; unilateral mainstem bronchus	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0783T	Transcutaneous auricular neurostimulation, set-up, calibration, and patient education on use of equipment	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0784T	Insertion or replacement of percutaneous electrode array, spinal. with integrated neurostimulator, including imaging guidance. wjem performed	Prior Authorization Required	Medical necessity including site of service	Submit recent history and physical, plan of care, and documentation of medical necessity including for site of service.
0785T	Revision or removal of neurostimulator electrode array, spinal, with integrated neurostimulator	Prior Authorization Required	Medical necessity including site of service	Submit recent history and physical, plan of care, and documentation of medical necessity including for site of service.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
0786T	Insertion or replacement of percutaneous electrode array, sacral, with integrated neurostimulator, including imaging guidance, when performed	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
0787T	Revision or removal of neurostimulator electrode array, sacral, with integrated neurostimulator	Pre-Service Review Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
0791T	Motor-cognitive, semi-immersive virtual reality-facilitated gait training, each 15 minutes (List separately in addition to code for primary procedure)	Retrospective Review	Outpatient Rehabilitation	For Alaska plans: After initial visit, submit online review at www.evicore.com. For Washington plans: After the first 6 treatment visits in an episode of care, submit online review at www.evicore.com.
0793T	Percutaneous transcatheter thermal ablation of nerves innervating the pulmonary arteries, including right heart catheterization, pulmonary artery angiography, and all imaging guidance	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0794T	Patient-specific, assistive, rules-based algorithm for ranking pharmaco-oncologic treatment options based on the patient's tumor-specific cancer marker information obtained from prior molecular pathology, immunohistochemical, or other pathology results which have been previously interpreted and reported separately	Possible Denial; Medical Records Optional	Investigative	Documentation optional.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
0795T	Transcatheter insertion of permanent dual-chamber leadless pacemaker, including imaging guidance (eg, fluoroscopy, venous ultrasound, right atrial angiography, right ventriculography, femoral venography) and device evaluation (eg, interrogation or programming), when performed; complete system (ie, right atrial and right ventricular pacemaker components)	Prior Authorization Required	Investigative	Submit history and physical, documentation of medical necessity and procedure report.
0796T	Transcatheter insertion of permanent dual-chamber leadless pacemaker, including imaging guidance (e.g., fluoroscopy, venous ultrasound, right atrial angiography, right ventriculography, femoral venography) and device evaluation (e.g., interrogation or programming), when performed; right atrial pacemaker component (when an existing right ventricular single leadless pacemaker exists to create a dual-chamber leadless pacemaker system)	Prior Authorization Required	Investigative	Submit history and physical, documentation of medical necessity and procedure report.
0797T	Transcatheter insertion of permanent dual-chamber leadless pacemaker, including imaging guidance (e.g., fluoroscopy, venous ultrasound, right atrial angiography, right ventriculography, femoral venography) and device evaluation (e.g., interrogation or programming), when performed; right ventricular pacemaker component (when part of a dual-chamber leadless pacemaker system)	Prior Authorization Required	Investigative	Submit history and physical, documentation of medical necessity and procedure report.

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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 Required	Investigative	Submit history and physical, documentation of medical necessity and procedure report.
0802T	Transcatheter removal and replacement of permanent dual-chamber leadless pacemaker, including imaging?guidance (eg, fluoroscopy, venous ultrasound, right atrial angiography, right ventriculography, femoral venography) and device evaluation (eg, interrogation or programming), when performed; right atrial pacemaker component	Prior Authorization Required	Investigative	Submit history and physical, documentation of medical necessity and procedure report.
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 Required	Investigative	Submit history and physical, documentation of medical necessity and procedure report.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
0807T	Pulmonary tissue ventilation analysis using software-based processing of data from separately captured cinefluorograph images; in combination with previously acquired computed tomography (CT) images, including data preparation and transmission, quantification of pulmonary tissue ventilation, data review, interpretation and report	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0808T	Pulmonary tissue ventilation analysis using software-based processing of data from separately captured cinefluorograph images; in combination with computed tomography (CT) images taken for the purpose of pulmonary tissue ventilation analysis, including data preparation and transmission, quantification of pulmonary tissue ventilation, data review, interpretation and report	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0810T	Subretinal injection of a pharmacologic agent, including vitrectomy and 1 or more retinotomies	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0811T	Remote multi-day complex uroflommetry (eg, calibrated electronic equipment); set-up and patient education on use of equipment	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0812T	Remote multi-day complex uroflommetry device supply with automated report generation, up to 10 days	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0813T	Esophagogastroduodenoscopy, flexible, transoral, with volume adjustment of intragastric bariatric balloon	Possible Denial; Medical Records Optional	Investigative	Documentation optional.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
0814T	Percutaneous injection of calcium-based biodegradable osteoconductive material, proximal femur, including imaging guidance, unilateral	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0816T	Open insertion or replacement of integrated neurostimulation system for bladder dysfunction including electrode(s) & pulse generator or receiver including analysis, programming & guidance	Pre-Service Review Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
0817T	Open insertion or replacement of integrated neurostimulation system for bladder dysfunction including electrode(s) & pulse generator or receiver including analysis, programming & imaging	Pre-Service Review Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
0818T	Revision or removal of integrated neurostimulation system for bladder dysfunction, including analysis, programming & imaging, when performed, posterior tibial nerve; subcutaneous	Pre-Service Review Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
0819T	Revision or removal of integrated neurostimulation system for bladder dysfunction, including analysis, programming & imaging, when performed, posterior tibial nerve; subfascial	Pre-Service Review Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
0820T	Continuous in-person monitoring & intervention as needed, during psychedelic medication therapy; first physician or other qualified health care professional, each hour	Possible Denial; Medical Records Optional	Investigative	Documentation optional.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
0821T	Continuous in-person monitoring & intervention as needed, during psychedelic medication therapy; second physician or other qualified health care professional, concurrent with first visit, each hour	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0822T	Continuous in-person monitoring & intervention as needed during psychedelic medication therapy; clinical staff under direction of a a physician or other qualified health care professional, each hour	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0823T	Transcatheter insertion of permanent single-chamber leadless pacemaker, right atrial, including imaging guidance and device evaluation when performed	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
0824T	Transcatheter removal of permanent single-chamber leadless pacemaker, right atrial, including imaging guidance when performed	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
0825T	Transcatheter removal and replacement of permanent single-chamber, leadless pacemaker, right atrial, including imaging guidance and device evaluation, when performed	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
0826T	Programming device evaluation with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
0827T	Digitization of glass microscope slides for cytopathology, fluids, washings, or brushings, except cervical or vaginal; smears with interpretation	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
0828T	Digitization of glass microscope slides for cytopathology, fluids, washings, or brushings, except cervical or vaginal; simple filter method with interpretation	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
0829T	Digitization of glass microscope slides for cytopathology, concentration technique, smears, and interpretation (eg, saccomanno technique)	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
0830T	Digitization of glass microscope slides for cytopathology, selective-cellular enhancement technique with interpretation except cervical & vaginal	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
0831T	Digitization of glass microscope slides for cytopathology, cervical or vaginal (any reporting system), requiring interpretation by physician	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
0832T	Digitization of glass microscope slides for cytopathology, smears, any other source; screening and interpretation (list separately in addition to code for primary procedure)	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
0833T	Digitization of glass microscope slides for cytopathology, smears, any other source; preparation, screening & interpretation	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
0834T	Digitization of glass microscope slides for cytopathology, smears, any other source; extended study involving over 5 slides and/or multiple stains	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
0835T	Digitization of glass microscope slides for cytopathology, evaluation of fine needle aspirate; immediate cytohistologic study to determine adequacy for diagnosis, first evaluation	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
0836T	Digitization of glass microscope slides for cytopathology, evaluation of fine needle aspirate; immediate cytohistologic study to determine adequacy for diagnosis, immediate cytohistologic study	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
0837T	Digitization of glass microscope slides for cytopathology, evaluation of fine needle aspirate; immediate cytohistologic study to determine adequacy for diagnosis. interpretation & report	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
0838T	Digitization of glass microscope slides for consultation and report on referred slides prepared elsewhere (list separately in addition to code for primary procedure)	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
0839T	Digitization of glass microscope slides for consultation and report on referred material requiring preparation of slides (list separately in addition to code for primary procedure)	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
0840T	Digitization of glass microscope slides for consultation, comprehensive, with review of records and specimens, with report on referred material	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
0841T	Digitization of glass microscope slides for pathology consultation during surgery; first tissue block, with frozen section(s), single specimen	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
0842T	Digitization of glass microscope slides for pathology consultation during surgery first tissue block, with frozen section(s), each additional tissue block with frozen section	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
0843T	Digitization of glass microscope slides for pathology consultation during surgery; first tissue block, with frozen section(s), cytologic examination, initial site	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
0844T	Digitation of glass microscope slides for pathology consult during surgery; first tissue block, with frozen section(s), cytologic exam, each additional site	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
0845T	Digitization of glass microscope slides for immunofluorescence, per specimen; initial single antibody stain procedure (list seperately in addition to code for primary procedure)	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
0846T	Digitization of glass microscope slides for immunofluorescence, per specimen; each additional single antibody stain procedure (list separately in addition to code for primary procedure)	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
0847T	Digitization of glass microscope slides for examination and selection of retrieved archival tissue(s) for molecular analysis	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
0848T	Digitization of glass microscope slides for in situ hybridization (eg, FISH), per specimen; initial single probe stain procedure	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.

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0849T	Digitization of glass microscope slides for in situ-hybridization (eg, FISH), per specimen; each additional single probe stain procedure	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
0850T	Digitization of glass microscope slides for in situ hybridization (eg, FISH), per specimen; each multiplex probe stain procedure	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
0851T	Digitization of glass microscope slides for morphometric analysis, in situ hybridization, manual, per specimen; initial single probe stain procedure	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
0852T	Digitization of glass microscope slides for morphometric analysis, in situ hybridization, manual, per specimen; each additional single probe stain procedure	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
0853T	Digitization of glass microscope slides for morphometric analysis, in situ hybridization, manual, per specimen; each multiplex probe stain procedure	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
0854T	Digitization of glass microscope slides for blood smear, peripheral, interpretation by physician with written report (list separately i addition to code for primary procedure)	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
0855T	Digitization of glass microscope slides for bone marrow, smear interpretation (list separately in addition to code for primary procedure)	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
0856T	Digitization of glass slides for electron microscopy, diagnostic (list separately in addition to code for primary procedure)	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.

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0858T	Externally applied transcranial magnetic stimulation with concomitant measurement of evoked cortical potentials with automated report	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0859T	Noncontract near-infrared spectroscopy other than for screening for peripheral arterial disease, image acquisition, interpretation, and report; each additional anatomic site	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0860T	Noncontact near-infrared spectroscopy for screening for peripheral arterial disease, including provocative maneuvers, image acquisition, interpretation & report, one or both lower extremities	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0864T	Low-intensity extracorporeal shock wave therapy involving corpus cavernosum, low energy	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0865T	Quantitative (MRI) analysis of the brain with comparison to prior magnetic resonance study, including lesion identification, characterization & quantification with brain volumes	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0866T	Quantitative (MRI) analysis of the brain with comparison to prior magnetic resonance including lesion detection, characterization & quantification with brain volume obtained with diagnostic MRI examination of the brain (list separately in addition to code for primary procedure)	Possible Denial; Medical Records Optional	Investigative	Documentation optional.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
0867T	Transperineal laser ablation of benign prostatic hyperplasia, including imaging guidance; prostate volume greater or equal to 50 mL	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0868T	High-resolution gastric electrophysiology mapping with simultaneous patient-symptom profiling, with interpretation and report	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0869T	Injection(s), bone-substitute material for bone and/or soft tissue hardware fixation augmentation, including intraoperative imaging guidance, when performed	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0870T	Implantation of subcutaneous peritoneal ascites pump system, percutaneous, including pump-pocket creation, insertion of tunneled indwelling bladder and peritoneal catheters with pump connections, including all imaging and initial programming, when performed	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0871T	Replacement of a subcutaneous peritoneal ascites pump, including reconnection between pump and indwelling bladder and peritoneal catheters, including initial programming and imaging, when performed	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0872T	Replacement of indwelling bladder and peritoneal catheters, including tunneling of catheter(s) and connection with previously implanted peritoneal ascites pump, including imaging and programming, when performed	Possible Denial; Medical Records Optional	Investigative	Documentation optional.

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0873T	Revision of a subcutaneously implanted peritoneal ascites pump system, any component (ascites pump, associated peritoneal catheter, associated bladder catheter), including imaging and programming, when performed	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0874T	Removal of a peritoneal ascites pump system, including implanted peritoneal ascites pump and indwelling bladder and peritoneal catheters	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0875T	Programming of subcutaneously implanted peritoneal ascites pump system by physician or other qualified health care professional	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0877T	Augmentative analysis of chest computed tomography (CT) imaging data to provide categorical diagnostic subtype classification of interstitial lung disease; obtained without concurrent CT examination of any structure contained in previously acquired diagnostic imaging	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0878T	Augmentative analysis of chest computed tomography (CT) imaging data to provide categorical diagnostic subtype classification of interstitial lung disease; obtained with concurrent CT examination of the same structure	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0879T	Augmentative analysis of chest computed tomography (CT) imaging data to provide categorical diagnostic subtype classification of interstitial lung disease; radiological data preparation and transmission	Possible Denial; Medical Records Optional	Investigative	Documentation optional.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
0880T	Augmentative analysis of chest computed tomography (CT) imaging data to provide categorical diagnostic subtype classification of interstitial lung disease; physician or other qualified health care professional interpretation and report	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0881T	Cryotherapy of the oral cavity using temperature regulated fluid cooling system, including placement of an oral device, monitoring of patient tolerance to treatment, and removal of the oral device	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0882T	Intraoperative therapeutic electrical stimulation of peripheral nerve to promote nerve regeneration, including lead placement and removal, upper extremity, minimum of 10 minutes; initial nerve (List separately in addition to code for primary procedure)	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0883T	Intraoperative therapeutic electrical stimulation of peripheral nerve to promote nerve regeneration, including lead placement and removal, upper extremity, minimum of 10 minutes; each additional nerve (List separately in addition to code for primary procedure)	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0887T	End-tidal control of inhaled anesthetic agents and oxygen to assist anesthesia care delivery (List separately in addition to code for primary procedure)	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0888T	Histotripsy (ie, non-thermal ablation via acoustic energy delivery) of malignant renal tissue, including imaging guidance	Possible Denial; Medical Records Optional	Investigative	Documentation optional.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
0889T	Personalized target development for accelerated, repetitive high-dose functional connectivity MRI-guided theta-burst stimulation derived from a structural and resting-state functional MRI, including data preparation and transmission, generation of the target, motor threshold-starting location, neuronavigation files and target report, review and interpretation	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0890T	Accelerated, repetitive high-dose functional connectivity MRI-guided theta-burst stimulation, including target assessment, initial motor threshold determination, neuronavigation, delivery and management, initial treatment day	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0891T	Accelerated, repetitive high-dose functional connectivity MRI-guided theta-burst stimulation, including neuronavigation, delivery and management, subsequent treatment day	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0892T	Accelerated, repetitive high-dose functional connectivity MRI-guided theta-burst stimulation, including neuronavigation, delivery and management, subsequent motor threshold redetermination with delivery and management, per treatment day	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0893T	Noninvasive assessment of blood oxygenation, gas exchange efficiency, and cardiorespiratory status, with physician or other qualified health care professional interpretation and report	Possible Denial; Medical Records Optional	Investigative	Documentation optional.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
0894T	Cannulation of the liver allograft in preparation for connection to the normothermic perfusion device and decannulation of the liver allograft following normothermic perfusion	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0895T	Connection of liver allograft to normothermic machine perfusion device, hemostasis control; initial 4 hours of monitoring time, including hourly physiological and laboratory assessments (eg, perfusate temperature, perfusate pH, hemodynamic parameters, bile production, bile pH, bile glucose, biliary bicarbonate, lactate levels, macroscopic assessment)	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0896T	Connection of liver allograft to normothermic machine perfusion device, hemostasis control; each additional hour, including physiological and laboratory assessments (eg, perfusate temperature, perfusate pH, hemodynamic parameters, bile production, bile pH, bile glucose, biliary bicarbonate, lactate levels, macroscopic assessment) (List separately in addition to code for primary procedure)	Possible Denial; Medical Records Optional	Investigative	Documentation optional.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
0897T	Noninvasive augmentative arrhythmia analysis derived from quantitative computational cardiac arrhythmia simulations, based on selected intervals of interest from 12-lead electrocardiogram and uploaded clinical parameters, including uploading clinical parameters with interpretation and report	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0898T	Noninvasive prostate cancer estimation map, derived from augmentative analysis of image-guided fusion biopsy and pathology, including visualization of margin volume and location, with margin determination and physician interpretation and report	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0899T	Noninvasive determination of absolute quantitation of myocardial blood flow (AQMBF), derived from augmentative algorithmic analysis of the dataset acquired via contrast cardiac magnetic resonance (CMR), pharmacologic stress, with interpretation and report by a physician or other qualified health care professional (List separately in addition to code for primary procedure)	Possible Denial; Medical Records Optional	Investigative	Documentation optional.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
0900T	Noninvasive estimate of absolute quantitation of myocardial blood flow (AQMBF), derived from assistive algorithmic analysis of the dataset acquired via contrast cardiac magnetic resonance (CMR), pharmacologic stress, with interpretation and report by a physician or other qualified health care professional (List separately in addition to code for primary procedure)	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0901T	Placement of bone marrow sampling port, including imaging guidance when performed	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0902	Behavioral Health Treatments/Services-Milieu Therapy	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
0902T	QTc interval derived by augmentative algorithmic analysis of input from an external, patient-activated mobile ECG device	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0903T	Electrocardiogram, algorithmically generated 12-lead ECG from a reduced-lead ECG; with interpretation and report	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0904T	Electrocardiogram, algorithmically generated 12-lead ECG from a reduced-lead ECG; tracing only	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0905T	Electrocardiogram, algorithmically generated 12-lead ECG from a reduced-lead ECG; interpretation and report only	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0906T	Concurrent optical and magnetic stimulation (COMS) therapy, wound assessment and dressing care; first application, total wound(s) surface area less than or equal to 50 sq cm	Possible Denial; Medical Records Optional	Medical Necessity	Documentation optional.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
0907	Behavioral Health Treatments - Community Behavioral Health Program (Day Treatment)	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
0907T	Concurrent optical and magnetic stimulation (COMS) therapy, wound assessment and dressing care; each additional application, total wound(s) surface area less than or equal to 50 sq cm (List separately in addition to code for primary procedure)	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0908T	Open implantation of integrated neurostimulation system, vagus nerve, including analysis and programming, when performed	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0909T	Replacement of integrated neurostimulation system, vagus nerve, including analysis and programming, when performed	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0910T	Removal of integrated neurostimulation system, vagus nerve	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0911T	Electronic analysis of implanted integrated neurostimulation system, vagus nerve; without programming by physician or other qualified health care professional	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0912T	Electronic analysis of implanted integrated neurostimulation system, vagus nerve; with simple programming by physician or other qualified health care professional	Possible Denial; Medical Records Optional	Investigative	Documentation optional.

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0913T	Percutaneous transcatheter therapeutic drug delivery by intracoronary drug-delivery balloon (eg, drug-coated, drug-eluting), including mechanical dilation by nondrug-delivery balloon angioplasty, endoluminal imaging using intravascular ultrasound (IVUS) or optical coherence tomography (OCT) when performed, imaging supervision, interpretation, and report, single major coronary artery or branch	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0914T	Percutaneous transcatheter therapeutic drug delivery by intracoronary drug-delivery balloon (eg, drug-coated, drug-eluting) performed on a separate target lesion from the target lesion treated with balloon angioplasty, coronary stent placement or coronary atherectomy, including mechanical dilation by nondrug-delivery balloon angioplasty, endoluminal imaging using intravascular ultrasound (IVUS) or optical coherence tomography (OCT) when performed, imaging supervision, interpretation, and report, single major coronary artery or branch (List separately in addition to code for percutaneous coronary stent or atherectomy intervention)	Possible Denial; Medical Records Optional	Investigative	Documentation optional.

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0915T	Insertion of permanent cardiac contractility modulation-defibrillation system component(s), including fluoroscopic guidance, and evaluation and programming of sensing and therapeutic parameters; pulse generator and dual transvenous electrodes/leads (pacing and defibrillation)	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0916T	Insertion of permanent cardiac contractility modulation-defibrillation system component(s), including fluoroscopic guidance, and evaluation and programming of sensing and therapeutic parameters; pulse generator only	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0917T	Insertion of permanent cardiac contractility modulation-defibrillation system component(s), including fluoroscopic guidance, and evaluation and programming of sensing and therapeutic parameters; single transvenous lead (pacing or defibrillation) only	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0918T	Insertion of permanent cardiac contractility modulation-defibrillation system component(s), including fluoroscopic guidance, and evaluation and programming of sensing and therapeutic parameters; dual transvenous leads (pacing and defibrillation) only	Possible Denial; Medical Records Optional	Investigative	Documentation optional.

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0919T	Removal of a permanent cardiac contractility modulation-defibrillation system component(s); pulse generator only	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0920T	Removal of a permanent cardiac contractility modulation-defibrillation system component(s); single transvenous pacing lead only	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0921T	Removal of a permanent cardiac contractility modulation-defibrillation system component(s); single transvenous defibrillation lead only	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0922T	Removal of a permanent cardiac contractility modulation-defibrillation system component(s); dual (pacing and defibrillation) transvenous leads only	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0923T	Removal and replacement of permanent cardiac contractility modulation-defibrillation pulse generator only	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0924T	Repositioning of previously implanted cardiac contractility modulation-defibrillation transvenous electrode(s)/lead(s), including fluoroscopic guidance and programming of sensing and therapeutic parameters	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0925T	Relocation of skin pocket for implanted cardiac contractility modulation-defibrillation pulse generator	Possible Denial; Medical Records Optional	Investigative	Documentation optional.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
0926T	Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, including review and report, implantable cardiac contractility modulation-defibrillation system	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0927T	Interrogation device evaluation (in person) with analysis, review, and report, including connection, recording, and disconnection, per patient encounter, implantable cardiac contractility modulation-defibrillation system	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0928T	Interrogation device evaluation (remote), up to 90 days, cardiac contractility modulation-defibrillation system with interim analysis and report(s) by a physician or other qualified health care professional	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0929T	Interrogation device evaluation (remote), up to 90 days, cardiac contractility modulation-defibrillation system, remote data acquisition(s), receipt of transmissions, technician review, technical support, and distribution of results	Possible Denial; Medical Records Optional	Investigative	Documentation optional.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
0930T	Electrophysiologic evaluation of cardiac contractility modulation-defibrillator leads, including defibrillation-threshold evaluation (induction of arrhythmia, evaluation of sensing and therapy for arrhythmia termination), at time of initial implantation or replacement with testing of cardiac contractility modulation-defibrillator pulse generator	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0931T	Electrophysiologic evaluation of cardiac contractility modulation-defibrillator leads, including defibrillation-threshold evaluation (induction of arrhythmia, evaluation of sensing and therapy for arrhythmia termination), separate from initial implantation or replacement with testing of cardiac contractility modulation-defibrillator pulse generator	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0932T	Noninvasive detection of heart failure derived from augmentative analysis of an echocardiogram that demonstrated preserved ejection fraction, with interpretation and report by a physician or other qualified health care professional	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0933T	Transcatheter implantation of wireless left atrial pressure sensor for long-term left atrial pressure monitoring, including sensor calibration and deployment, right heart catheterization, transseptal puncture, imaging guidance, and radiological supervision and interpretation	Possible Denial; Medical Records Optional	Investigative	Documentation optional.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
0934T	Remote monitoring of a wireless left atrial pressure sensor for up to 30 days, including data from daily uploads of left atrial pressure recordings, interpretation(s) and trend analysis, with adjustments to the diuretics plan, treatment paradigm thresholds, medications or lifestyle modifications, when performed, and report(s) by a physician or other qualified health care professional	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0935T	Cystourethroscopy with renal pelvic sympathetic denervation, radiofrequency ablation, retrograde ureteral approach, including insertion of guide wire, selective placement of ureteral sheath(s) and multiple conformable electrodes, contrast injection(s), and fluoroscopy, bilateral	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0936T	Photobiomodulation therapy of retina, single session	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0937T	External electrocardiographic recording for greater than 15 days up to 30 days by continuous rhythm recording and storage; including recording, scanning analysis with report, review and interpretation by a physician or other qualified health care professional	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0938T	External electrocardiographic recording for greater than 15 days up to 30 days by continuous rhythm recording and storage; recording (including connection and initial recording)	Possible Denial; Medical Records Optional	Investigative	Documentation optional.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
0939T	External electrocardiographic recording for greater than 15 days up to 30 days by continuous rhythm recording and storage; scanning analysis with report	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0940T	External electrocardiographic recording for greater than 15 days up to 30 days by continuous rhythm recording and storage; review and interpretation by a physician or other qualified health care professional	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0941	Other Therapeutic Services - Recreational Therapy	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
0941T	Cystourethroscopy, flexible; with insertion and expansion of prostatic urethral scaffold using integrated cystoscopic visualization	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0942T	Cystourethroscopy, flexible; with removal and replacement of prostatic urethral scaffold	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0943T	Cystourethroscopy, flexible; with removal of prostatic urethral scaffold	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0944T	3D contour simulation of target liver lesion(s) and margin(s) for image-guided percutaneous microwave ablation	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0945T	Intraoperative assessment for abnormal (tumor) tissue, in-vivo, following partial mastectomy (eg, lumpectomy) using computer-aided fluorescence imaging (List separately in addition to code for primary procedure)	Possible Denial; Medical Records Optional	Investigative	Documentation optional.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
0946T	Orthopedic implant movement analysis using paired computed tomography (CT) examination of the target structure, including data acquisition, data preparation and transmission, interpretation and report (including CT scan of the joint or extremity performed with paired views)	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0947T	Magnetic resonance image guided low intensity focused ultrasound (MRgFUS), stereotactic blood-brain barrier disruption using microbubble resonators to increase the concentration of blood-based biomarkers of target, intracranial, including stereotactic navigation and frame placement, when performed	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
0951	Other Therapeutic Services - Athletic Training	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
0952	Other Therapeutic Services - Kinesiotherapy Training	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
0990	Patient Convenience Items - General Classification	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
0991	Patient Convenience Items - Charges for Cafeteria/Guest Trays	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
0992	Patient Convenience Items - Charges for Private Linen Service	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
0993	Patient Convenience Items - Charges for Telephone/Telegraph	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
0994	Patient Convenience Items - TV/Radio	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
0995	Patient Convenience Items - Nonpatient Room Rentals	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
0996	Patient Convenience Items - Late Discharge Charge	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.

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0998	Patient Convenience Items - Beauty Shop/Barber	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
0999	Patient Convenience Items - Other Patient Convenience Item	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
1001	Behavioral Health Accommodations-Residential -Psychiatric	Prior Authorization Required	Medical Necessity	Submit plan of care and documentation of medical necessity.
1002	Behavioral Health Accommodations-Residential-Chemical Dependency	Prior Authorization Required	Medical Necessity	Submit plan of care and documentation of medical necessity.
1006	Behavioral Health Accommodations-Outdoor/Wilderness Behavioral Health	Prior Authorization Required	Medical Necessity	Submit plan of care and documentation of medical necessity.
11920	Tattooing, intradermal introduction of insoluble opaque pigments to correct color defects of skin, including micropigmentation; 6.0 sq cm or less	Possible Denial; Medical Records Optional	Cosmetic	Pre Operative evaluation, History and Physical including functional impairment, and operative report.
11921	Tattooing, intradermal introduction of insoluble opaque pigments to correct color defects of skin, including micropigmentation; 6.1 to 20.0 sq cm	Possible Denial; Medical Records Optional	Cosmetic	Pre Operative evaluation, History and Physical including functional impairment, and operative report.
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)	Possible Denial; Medical Records Optional	Cosmetic	Pre Operative evaluation, History and Physical including functional impairment, and operative report.
11950	Subcutaneous injection of filling material (eg, collagen); 1 cc or less	Possible Denial; Medical Records Optional	Cosmetic	Pre Operative Evaluation, History and Physical including functional impairment, and Operative report
11951	Subcutaneous injection of filling material (eg, collagen); 1.1 to 5.0 cc	Possible Denial; Medical Records Optional	Cosmetic	Pre Operative Evaluation, History and Physical including functional impairment, and Operative report
11952	Subcutaneous injection of filling material (eg, collagen); 5.1 to 10.0 cc	Possible Denial; Medical Records Optional	Cosmetic	Pre Operative Evaluation, History and Physical including functional impairment, and Operative report

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
11954	Subcutaneous injection of filling material (eg, collagen); over 10.0 cc	Possible Denial; Medical Records Optional	Cosmetic	Pre Operative Evaluation, History and Physical including functional impairment, and Operative report
11970	Replacement of tissue expander with permanent implant	Prior Authorization Required	Cosmetic - Reconstructive	Pre Operative Evaluation, History and Physical including functional impairment and Operative report.
11971	Removal of tissue expander without insertion of implant	Prior Authorization Required	Cosmetic - Reconstructive	Pre Operative Evaluation, History and Physical including functional impairment and Operative report.
15011	Harvest of skin for skin cell suspension autograft; first 25 sq cm or less	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
15012	Harvest of skin for skin cell suspension autograft; each additional 25 sq cm or part thereof (List separately in addition to code for primary procedure)	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
15013	Preparation of skin cell suspension autograft, requiring enzymatic processing, manual mechanical disaggregation of skin cells, and filtration; first 25 sq cm or less of harvested skin	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
15014	Preparation of skin cell suspension autograft, requiring enzymatic processing, manual mechanical disaggregation of skin cells, and filtration; each additional 25 sq cm of harvested skin or part thereof (List separately in addition to code for primary procedure)	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
15015	Application of skin cell suspension autograft to wound and donor sites, including application of primary dressing, trunk, arms, legs; first 480 sq cm or less	Possible Denial; Medical Records Optional	Investigative	Documentation optional.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
15016	Application of skin cell suspension autograft to wound and donor sites, including application of primary dressing, trunk, arms, legs; each additional 480 sq cm or part thereof (List separately in addition to code for primary procedure)	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
15017	Application of skin cell suspension autograft to wound and donor sites, including application of primary dressing, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; first 480 sq cm or less	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
15018	Application of skin cell suspension autograft to wound and donor sites, including application of primary dressing, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; each additional 480 sq cm or part thereof (List separately in addition to code for primary procedure)	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
15771	Grafting of autologous fat harvested by liposuction technique to trunk, breasts, scalp, arms, and/or legs; 50 cc or less injectate	Possible Denial; Medical Records Optional	Cosmetic	Submit history and physical, documentation of medical necessity and procedure report.
15772	Grafting of autologous fat harvested by liposuction technique to trunk, breasts, scalp, arms, and/or legs; each additional 50 cc injectate, or part thereof (list separately in addition to code for primary procedure)	Possible Denial; Medical Records Optional	Cosmetic	Submit history and physical, documentation of medical necessity and procedure report.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
15773	Grafting of autologous fat harvested by liposuction technique to face, eyelids, mouth, neck, ears, orbits, genitalia, hands, and/or feet; 25 cc or less injectate	Possible Denial; Medical Records Optional	Cosmetic	Submit history and physical, documentation of medical necessity and procedure report.
15774	Grafting of autologous fat harvested by liposuction technique to face, eyelids, mouth, neck, ears, orbits, genitalia, hands, and/or feet; each additional 25 cc injectate, or part thereof (list separately in addition to code for primary procedure)	Possible Denial; Medical Records Optional	Cosmetic	Submit history and physical, documentation of medical necessity and procedure report.
15775	Punch graft for hair transplant; 1 to 15 punch grafts	Non-covered Service	Benefit Exception	Submit records only when member's contract indicates coverage. Beginning 1/1/22 code will require review for WA members when submitted for gender transition/affirmation surgery unless otherwise specified by contract.
15776	Punch graft for hair transplant; more than 15 punch grafts	Non-covered Service	Benefit Exception	Submit records only when member's contract indicates coverage. Beginning 1/1/22 code will require review for WA members when submitted for gender transition/affirmation surgery unless otherwise specified by contract.
15780	Dermabrasion; total face (eg, for acne scarring, fine wrinkling, rhytids, general keratosis)	Possible Denial; Medical Records Optional	Cosmetic	Recent History and Physical, plan of care, and documentation of medical necessity
15781	Dermabrasion; segmental, face	Pre-Service Review Required	Cosmetic	Recent History and Physical, plan of care, and documentation of medical necessity
15782	Dermabrasion; regional, other than face	Pre-Service Review Required	Cosmetic	Recent History and Physical, plan of care, and documentation of medical necessity

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
15783	Dermabrasion; superficial, any site (eg, tattoo removal)	Possible Denial; Medical Records Optional	Cosmetic	Recent History and Physical, plan of care, and documentation of medical necessity
15786	Abrasion; single lesion (eg, keratosis, scar)	Possible Denial; Medical Records Optional	Cosmetic	Pre Operative Evaluation, History and Physical including functional impairment, and Operative report
15787	Abrasion; each additional 4 lesions or less (List separately in addition to code for primary procedure)	Possible Denial; Medical Records Optional	Cosmetic	Pre Operative Evaluation, History and Physical including functional impairment, and Operative report
15788	Chemical peel, facial; epidermal	Prior Authorization Required	Medical Necessity	Beginning 1/1/22 will only require review for WA members when submitted for gender transition/affirmation surgery. Submit history and physical, documentation of medical necessity and procedure report.
15789	Chemical peel, facial; dermal	Prior Authorization Required	Medical Necessity	Beginning 1/1/22 will only require review for WA members when submitted for gender transition/affirmation surgery. Submit history and physical, documentation of medical necessity and procedure report.
15792	Chemical peel, nonfacial; epidermal	Prior Authorization Required	Medical Necessity	Beginning 1/1/22 will only require review for WA members when submitted for gender transition/affirmation surgery. Submit history and physical, documentation of medical necessity and procedure report.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
15793	Chemical peel, nonfacial; dermal	Prior Authorization Required	Medical Necessity	Beginning 1/1/22 will only require review for WA members when submitted for gender transition/affirmation surgery. Submit history and physical, documentation of medical necessity and procedure report.
15820	Blepharoplasty, lower eyelid	Prior Authorization Required	Medical Necessity	Pre Operative Evaluation, History and Physical including functional impairment, operative report and photographs of the affected eyes.
15821	Blepharoplasty, lower eyelid; with extensive herniated fat pad	Prior Authorization Required	Medical Necessity	Pre Operative Evaluation, History and Physical including functional impairment, operative report and photographs of the affected eyes.
15822	Blepharoplasty, upper eyelid	Prior Authorization Required	Medical Necessity	Pre Operative Evaluation, History and Physical including functional impairment, operative report and photographs of the affected eyes.
15823	Blepharoplasty, upper eyelid; with excessive skin weighting down lid	Prior Authorization Required	Medical Necessity	Pre Operative Evaluation, History and Physical including functional impairment, operative report and photographs of the affected eyes.
15824	Rhytidectomy; forehead	Prior Authorization Required	Cosmetic	Pre Operative Evaluation, History and Physical including functional impairment, and Operative report
15825	Rhytidectomy; neck with platysmal tightening (platysmal flap, P-flap)	Prior Authorization Required	Cosmetic	Pre Operative Evaluation, History and Physical including functional impairment, and Operative report
15826	Rhytidectomy; glabellar frown lines	Prior Authorization Required	Cosmetic	Pre Operative Evaluation, History and Physical including functional impairment, and Operative report

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15828	Rhytidectomy; cheek, chin, and neck	Prior Authorization Required	Cosmetic	Pre Operative Evaluation, History and Physical including functional impairment, and Operative report
15829	Rhytidectomy; superficial musculoaponeurotic system (SMAS) flap	Prior Authorization Required	Cosmetic	Pre Operative Evaluation, History and Physical including functional impairment, and Operative report
15830	Excision, excessive skin and subcutaneous tissue (includes lipectomy); abdomen, infraumbilical panniculectomy	Prior Authorization Required	Medical Necessity	Pre Operative Evaluation, History and Physical including functional impairment, photos and Operative report
15832	Excision, excessive skin and subcutaneous tissue (includes lipectomy); thigh	Prior Authorization Required	Cosmetic	Pre Operative Evaluation, History and Physical including functional impairment, and Operative report
15833	Excision, excessive skin and subcutaneous tissue (includes lipectomy); leg	Prior Authorization Required	Cosmetic	Pre Operative Evaluation, History and Physical including functional impairment, and Operative report
15834	Excision, excessive skin and subcutaneous tissue (includes lipectomy); hip	Prior Authorization Required	Cosmetic	Pre Operative Evaluation, History and Physical including functional impairment, and Operative report
15835	Excision, excessive skin and subcutaneous tissue (includes lipectomy); buttock	Prior Authorization Required	Cosmetic	Pre Operative Evaluation, History and Physical including functional impairment, and Operative report
15836	Excision, excessive skin and subcutaneous tissue (includes lipectomy); arm	Prior Authorization Required	Cosmetic	Pre Operative Evaluation, History and Physical including functional impairment, and Operative report
15837	Excision, excessive skin and subcutaneous tissue (includes lipectomy); forearm or hand	Prior Authorization Required	Cosmetic	Pre Operative Evaluation, History and Physical including functional impairment, and Operative report
15838	Excision, excessive skin and subcutaneous tissue (includes lipectomy); submental fat pad	Prior Authorization Required	Cosmetic	Pre Operative Evaluation, History and Physical including functional impairment, and Operative report
15839	Excision, excessive skin and subcutaneous tissue (includes lipectomy); other area	Prior Authorization Required	Cosmetic	Pre Operative Evaluation, History and Physical including functional impairment, and Operative report

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15847	Excision, excessive skin and subcutaneous tissue (includes lipectomy), abdomen (eg, abdominoplasty) (includes umbilical transposition and fascial plication) (List separately in addition to code for primary procedure)	Prior Authorization Required	Cosmetic	Pre Operative Evaluation, History and Physical including functional impairment, photos and Operative report
15876	Suction assisted lipectomy; head and neck	Prior Authorization Required	Cosmetic	Pre Operative Evaluation, History and Physical including functional impairment, and Operative report
15877	Suction assisted lipectomy; trunk	Prior Authorization Required	Cosmetic	Pre Operative Evaluation, History and Physical including functional impairment, and Operative report
15878	Suction assisted lipectomy; upper extremity	Prior Authorization Required	Cosmetic	Pre Operative Evaluation, History and Physical including functional impairment, and Operative report
15879	Suction assisted lipectomy; lower extremity	Prior Authorization Required	Cosmetic	Pre Operative Evaluation, History and Physical including functional impairment, and Operative report
15999	Unlisted procedure, excision pressure ulcer	Medical necessity review will be performed upon claims submission with supporting documentation.	Medical Necessity	Review required at claims submission; submit description of procedure with supporting documentation (including operative report if surgical) only for the date of service performed.
17106	Destruction of cutaneous vascular proliferative lesions (eg, laser technique); less than 10 sq cm	Prior Authorization Required	Cosmetic	Submit history and physical, documentation of medical necessity and procedure report.
17107	Destruction of cutaneous vascular proliferative lesions (eg, laser technique); 10.0 to 50.0 sq cm	Prior Authorization Required	Cosmetic	Submit history and physical, documentation of medical necessity and procedure report.
17108	Destruction of cutaneous vascular proliferative lesions (eg, laser technique); over 50.0 sq cm	Prior Authorization Required	Cosmetic	Submit history and physical, documentation of medical necessity and procedure report.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
17380	Electrolysis epilation, each 30 minutes	Non-covered Service	Benefit Exception	Submit records only if WA member in relation to gender transition/affirmation, including the reason for the procedure
17999	Unlisted procedure, skin, mucous membrane and subcutaneous tissue	Medical necessity review will be performed upon claims submission with supporting documentation.	Medical Necessity	Review required at claims submission; submit description of procedure with supporting documentation (including operative report if surgical) only for the date of service performed.
19105	Ablation, cryosurgical, of fibroadenoma, including ultrasound guidance, each fibroadenoma	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
19296	Placement of radiotherapy after loading balloon catheter into the breast for interstitial radioelement application following partial mastectomy, includes imaging guidance; on date separate from partial mastectomy	Prior Authorization Required	Radiation Oncology	No review for non-cancer diagnoses. FOR CANCER DIAGNOSES ONLY: Submit online review with Carelon at www.providerportal.com. For prior authorization include history and physical, results of previous diagnostics procedure report.
19297	Placement of radiotherapy after loading balloon catheter into the breast for interstitial radioelement application following partial mastectomy, includes imaging guidance; concurrent with partial mastectomy	Prior Authorization Required	Radiation Oncology	No review for non-cancer diagnoses. FOR CANCER DIAGNOSES ONLY: Submit online review with Carelon at www.providerportal.com. For prior authorization include history and physical, results of previous diagnostics procedure report.
19298	Placement of radiotherapy after loading brachytherapy catheters (multiple tube and balloon type) into the breast for interstitial radioelement application following (at time of or subsequent to) partial mastectomy, includes imaging guidance.	Prior Authorization Required	Radiation Oncology	No review for non-cancer diagnoses. FOR CANCER DIAGNOSES ONLY: Submit online review with Carelon at www.providerportal.com. For prior authorization include history and physical, results of previous diagnostics procedure report.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
19300	Mastectomy for gynecomastia	Prior Authorization Required	Medical Necessity	Pre Operative Office Evaluation, Pathology report, Operative report, Age, Medication Records, Length of time condition present
19303	Mastectomy, simple, complete	Prior Authorization Required	Medical Necessity	Submit pre-operative evaluation, pathology report, operative report including age, medication records, length of time condition present.
19316	Mastopexy	Prior Authorization Required	Cosmetic - Reconstructive	Pre Operative Evaluation, History and Physical including functional impairment and Operative report.
19318	Breast reduction	Prior Authorization Required	Medical necessity including site of service	Site of service, pre-operative evaluation, height/ weight, previous conservative treatment tried, pathology report, operative report, number of grams of tissue removed.
19325	Breast augmentation with implant	Prior Authorization Required	Cosmetic - Reconstructive	Pre Operative evaluation, History and Physical including functional impairment, and operative report.
19328	Removal of intact breast implant	Prior Authorization Required	Cosmetic - Reconstructive	Pre Operative evaluation, History and Physical including functional impairment, and operative report.
19330	Removal of ruptured breast implant, including implant contents (eg, saline, silicone gel)	Prior Authorization Required	Cosmetic - Reconstructive	Pre Operative evaluation, History and Physical including functional impairment, and operative report.
19340	Insertion of breast implant on same day of mastectomy (ie, immediate)	Prior Authorization Required	Cosmetic - Reconstructive	Pre Operative evaluation, History and Physical including functional impairment, and operative report.
19342	Insertion or replacement of breast implant on separate day from mastectomy	Prior Authorization Required	Cosmetic - Reconstructive	Pre Operative evaluation, History and Physical including functional impairment, and operative report.
19350	Nipple/areola reconstruction	Prior Authorization Required	Cosmetic - Reconstructive	Pre Operative evaluation, History and Physical including functional impairment, and operative report.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
19355	Correction of inverted nipples	Prior Authorization Required	Cosmetic	Pre Operative Evaluation, History and Physical including functional impairment, and Operative report
19357	Tissue expander placement in breast reconstruction, including subsequent expansion(s)	Prior Authorization Required	Cosmetic - Reconstructive	Pre Operative evaluation, History and Physical including functional impairment, and operative report.
19370	Revision of peri-implant capsule, breast, including capsulotomy, capsulorrhaphy, and/or partial capsulectomy	Prior Authorization Required	Cosmetic - Reconstructive	Pre Operative Evaluation, History and Physical including functional impairment and Operative report.
19371	Peri-implant capsulectomy, breast, complete, including removal of all intracapsular contents	Prior Authorization Required	Cosmetic - Reconstructive	Pre Operative Evaluation, History and Physical including functional impairment and Operative report.
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 Required	Cosmetic - Reconstructive	Pre Operative evaluation, History and Physical including functional impairment, and operative report.
19499	Unlisted procedure breast	Medical necessity review will be performed upon claims submission with supporting documentation.	Medical Necessity	Review required at claims submission; submit description of procedure with supporting documentation (including operative report if surgical) only for the date of service performed.
20555	Placement of needles or catheters into muscle and/or soft tissue for subsequent interstitial radioelement application (at the time of or subsequent to the procedure)	Prior Authorization Required	Radiation Oncology	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
20560	Needle insertion(s) without injection(s); 1 or 2 muscle(s)	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
20561	Needle insertion(s) without injection(s); 3 or more muscles	Possible Denial; Medical Records Optional	Investigative	Documentation optional.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
20974	Electrical stimulation to aid bone healing; noninvasive (nonoperative)	Prior Authorization Required	Medical Necessity	History and Physical indicating location of fracture, any member comorbidities. If request is for non union fracture, include date of fracture, serial radiographs detailing history of healing, documentation of adequacy of immobilization.
20975	Electrical stimulation to aid bone healing; invasive (operative)	Prior Authorization Required	Medical Necessity	History and Physical indicating location of fracture, any member comorbidities. If request is for non union fracture, include date of fracture, serial radiographs detailing history of healing, documentation of adequacy of immobilization.
20979	Low intensity ultrasound stimulation to aid bone healing, noninvasive (nonoperative)	Prior Authorization Required	Medical Necessity	Date of original fracture, History and Physical including comorbidities, fracture location, serial radiographs showing nonhealing and fracture gap
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 Required	Medical Necessity	History and physical, documentation of medical necessity, operative report.
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 Required	Investigative	Submit history and physical, documentation of medical necessity and procedure report.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
20999	Unlisted procedure, musculoskeletal system, general	Medical necessity review will be performed upon claims submission with supporting documentation.	Medical Necessity	Review required at claims submission; submit description of procedure with supporting documentation (including operative report if surgical) only for the date of service performed.
21010	Arthrotomy, temporomandibular joint	Prior Authorization Required	Medical Necessity	Submit diagnosis, prognosis and chart notes including history of non-invasive or non-surgical attempts to treat the TMJ. Fax to Dental Review @ 425-918-5956
21050	Condylectomy, temporomandibular joint (separate procedure)	Prior Authorization Required	Medical Necessity	Submit diagnosis, prognosis and chart notes including history of non-invasive or non-surgical attempts to treat the TMJ. Fax to Dental Review @ 425-918-5956
21060	Meniscectomy, partial or complete, temporomandibular joint (separate procedure)	Prior Authorization Required	Medical Necessity	Submit diagnosis, prognosis and chart notes including history of non-invasive or non-surgical attempts to treat the TMJ. Fax to Dental Review @ 425-918-5956
21073	Manipulation of temporomandibular joint(s) (TMJ), therapeutic, requiring an anesthesia service (ie, general or monitored anesthesia care)	Pre-Service Review Required	Medical Necessity	Submit diagnosis, prognosis and chart notes including history of non-invasive or non-surgical attempts to treat the TMJ. Fax to Dental Review @ 425-918-5956
21085	Impression and custom preparation; oral surgical splint	Prior Authorization Required	Medical Necessity	This code is only reviewed when a code from the diagnosis code range M26.601-M26.609 is billed. If the provider is an MD fax to IHM @ 800-843-1114; If the provider is a DDS or DMD fax to Dental Review @ 425-918-5956

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
21087	Impression and custom preparation; nasal prosthesis	Prior Authorization Required	Medical Necessity	Beginning 1/1/22 will only require review for WA members when submitted for gender transition/affirmation surgery. Submit history and physical, documentation of medical necessity and procedure report.
21088	Impression and custom preparation; facial prosthesis	Pre-Service Review Required	Cosmetic - Reconstructive	Submit chart notes including type of appliance, history of re-occurring TMJ and copy of diagnostic sleep studies. Fax to Dental Review @ 425-918-5956.
21089	Unlisted maxillofacial prosthetic procedure	Pre-Service Review Required	Medical Necessity	Submit chart notes including type of appliance, history of re-occurring TMJ and copy of diagnostic sleep studies. Fax to Dental Review @ 425-918-5956.
21116	Injection procedure for temporomandibular joint arthrography	Pre-Service Review Required	Medical Necessity	History and Physical, documentation of medical necessity.
21120	Genioplasty; augmentation (autograft, allograft, prosthetic material)	Possible Denial; Medical Records Optional	Cosmetic	Submit cephalometric, panoramic films and photos, age and history of orthodontic treatment. Fax to Dental Review @ 425-918-5956
21121	Genioplasty; sliding osteotomy, single piece	Possible Denial; Medical Records Optional	Cosmetic	MDs fax to IHM at 800-843-1114; DDS or DMDs: Complete the Dental Prior Authorization form found at: https://www.premera.com/documents/030000.pdf and FAX completed form to Dental Review at 425-918-5956. DDS & DMD: Submit cephalometric, panoramic films and photos, age and history of orthodontic treatment
21122	Genioplasty; sliding osteotomies, 2 or more osteotomies (eg, wedge excision or bone wedge reversal for asymmetrical chin)	Possible Denial; Medical Records Optional	Cosmetic	Submit cephalometric, panoramic films and photos, age and history of orthodontic treatment. Fax to Dental Review @ 425-918-5956

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
21123	Genioplasty; sliding, augmentation with interpositional bone grafts (includes obtaining autografts)	Possible Denial; Medical Records Optional	Cosmetic	Submit cephalometric, panoramic films and photos, age and history of orthodontic treatment. Fax to Dental Review @ 425-918-5956
21125	Augmentation, mandibular body or angle; prosthetic material	Pre-Service Review Required	Medical Necessity	Submit cephalometric, panoramic films and photos, age and history of orthodontic treatment. Fax to Dental Review @ 425-918-5956
21127	Augmentation, mandibular body or angle; with bone graft, onlay or interpositional (includes obtaining autograft)	Pre-Service Review Required	Medical Necessity	Submit cephalometric, panoramic films and photos, age and history of orthodontic treatment. Fax to Dental Review @ 425-918-5956
21137	Reduction forehead; contouring only	Prior Authorization Required	Medical Necessity	History and Physical, documentation of medical necessity and previous stages of reconstruction if done
21138	Reduction forehead; contouring and application of prosthetic material or bone graft (includes obtaining autograft)	Prior Authorization Required	Medical Necessity	History and Physical, documentation of medical necessity and previous stages of reconstruction if done
21139	Reduction forehead; contouring and setback of anterior frontal sinus wall	Prior Authorization Required	Medical Necessity	History and Physical, documentation of medical necessity and previous stages of reconstruction if done
21141	Reconstruction midface, LeFort I; single piece, segment movement in any direction (eg, for Long Face Syndrome), without bone graft	Prior Authorization Required	Medical Necessity	MDs fax to IHM at 800-843-1114; DDS or DMDs: Complete the Dental Prior Authorization form found at: https://www.premera.com/documents/030000.pdf and FAX completed form to Dental Review at 425-918-5956. DDS & DMD: Submit cephalometric, panoramic films and photos, age and history of orthodontic treatment

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
21142	Reconstruction midface, LeFort I; 2 pieces, segment movement in any direction, without bone graft	Pre-Service Review Required	Medical Necessity	MDs fax to IHM at 800-843-1114; DDS or DMDs: Complete the Dental Prior Authorization form found at: https://www.premera.com/documents/030000.pdf and FAX completed form to Dental Review at 425-918-5956. DDS & DMD: Submit cephalometric, panoramic films and photos, age and history of orthodontic treatment
21143	Reconstruction midface, LeFort I; 3 or more pieces, segment movement in any direction, without bone graft	Pre-Service Review Required	Medical Necessity	MDs fax to IHM at 800-843-1114; DDS or DMDs: Complete the Dental Prior Authorization form found at: https://www.premera.com/documents/030000.pdf and FAX completed form to Dental Review at 425-918-5956. DDS & DMD: Submit cephalometric, panoramic films and photos, age and history of orthodontic treatment
21145	Reconstruction midface, LeFort I; single piece, segment movement in any direction, requiring bone grafts (includes obtaining autografts)	Pre-Service Review Required	Medical Necessity	MDs fax to IHM at 800-843-1114; DDS or DMDs: Complete the Dental Prior Authorization form found at: https://www.premera.com/documents/030000.pdf and FAX completed form to Dental Review at 425-918-5956. DDS & DMD: Submit cephalometric, panoramic films and photos, age and history of orthodontic treatment

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
21146	Reconstruction midface, LeFort I; 2 pieces, segment movement in any direction, requiring bone grafts (includes obtaining autografts) (eg, ungrafted unilateral alveolar cleft)	Pre-Service Review Required	Medical Necessity	MDs fax to IHM at 800-843-1114; DDS or DMDs: Complete the Dental Prior Authorization form found at: https://www.premera.com/documents/030000.pdf and FAX completed form to Dental Review at 425-918-5956. DDS & DMD: Submit cephalometric, panoramic films and photos, age and history of orthodontic treatment
21147	Reconstruction midface, LeFort I; 3 or more pieces, segment movement in any direction, requiring bone grafts (includes obtaining autografts) (eg, ungrafted bilateral alveolar cleft or multiple osteotomies)	Pre-Service Review Required	Medical Necessity	MDs fax to IHM at 800-843-1114; DDS or DMDs: Complete the Dental Prior Authorization form found at: https://www.premera.com/documents/030000.pdf and FAX completed form to Dental Review at 425-918-5956. DDS & DMD: Submit cephalometric, panoramic films and photos, age and history of orthodontic treatment
21150	Reconstruction midface, LeFort II; anterior intrusion (eg, Treacher-Collins Syndrome)	Pre-Service Review Required	Medical Necessity	Submit cephalometric, panoramic films and photos, age and history of orthodontic treatment. Fax to Dental Review @ 425-918-5956
21151	Reconstruction midface, LeFort II; any direction, requiring bone grafts (includes obtaining autografts)	Pre-Service Review Required	Medical Necessity	Submit cephalometric, panoramic films and photos, age and history of orthodontic treatment. Fax to Dental Review @ 425-918-5956
21154	Reconstruction midface, LeFort III (extracranial), any type, requiring bone grafts (includes obtaining autografts); without LeFort I	Pre-Service Review Required	Medical Necessity	Submit cephalometric, panoramic films and photos, age and history of orthodontic treatment. Fax to Dental Review @ 425-918-5956
21155	Reconstruction midface, LeFort III (extracranial), any type, requiring bone grafts (includes obtaining autografts); with LeFort I	Pre-Service Review Required	Medical Necessity	Submit cephalometric, panoramic films and photos, age and history of orthodontic treatment. Fax to Dental Review @ 425-918-5956

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
21159	Reconstruction midface, LeFort III (extra and intracranial) with forehead advancement (eg, mono bloc), requiring bone grafts (includes obtaining autografts); without LeFort I	Pre-Service Review Required	Medical Necessity	Submit cephalometric, panoramic films and photos, age and history of orthodontic treatment. Fax to Dental Review @ 425-918-5956
21160	Reconstruction midface, LeFort III (extra and intracranial) with forehead advancement (eg, mono bloc), requiring bone grafts (includes obtaining autografts); with LeFort I	Pre-Service Review Required	Medical Necessity	Submit cephalometric, panoramic films and photos, age and history of orthodontic treatment. Fax to Dental Review @ 425-918-5956
21188	Reconstruction midface, osteotomies (other than LeFort type) and bone grafts (includes obtaining autografts)	Prior Authorization Required	Cosmetic - Reconstructive	Pre Operative Evaluation, History and Physical including functional impairment, and Operative report
21193	Reconstruction of mandibular rami, horizontal, vertical, C, or L osteotomy; without bone graft	Pre-Service Review Required	Medical Necessity	Submit cephalometric, panoramic films and photos, age and history of orthodontic treatment. Fax to Dental Review @ 425-918-5956
21194	Reconstruction of mandibular rami, horizontal, vertical, C, or L osteotomy; with bone graft (includes obtaining graft)	Pre-Service Review Required	Medical Necessity	Submit cephalometric, panoramic films and photos, age and history of orthodontic treatment. Fax to Dental Review @ 425-918-5956
21195	Reconstruction of mandibular rami and/or body, sagittal split; without internal rigid fixation	Pre-Service Review Required	Medical Necessity	Submit cephalometric, panoramic films and photos, age and history of orthodontic treatment. Fax to Dental Review @ 425-918-5956
21196	Reconstruction of mandibular rami and/or body, sagittal split; with internal rigid fixation	Pre-Service Review Required	Medical Necessity	Submit cephalometric, panoramic films and photos, age and history of orthodontic treatment. Fax to Dental Review @ 425-918-5956
21198	Osteotomy, mandible, segmental;	Pre-Service Review Required	Medical Necessity	Submit cephalometric, panoramic films and photos, age and history of orthodontic treatment. Fax to Dental Review @ 425-918-5956

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
21199	Osteotomy, mandible, segmental; with genioglossus advancement	Pre-Service Review Required	Medical Necessity	Submit cephalometric, panoramic films and photos, age and history of orthodontic treatment. Fax to Dental Review @ 425-918-5956
21206	Osteotomy, maxilla, segmental (eg, Wassmund or Schuchard)	Pre-Service Review Required	Medical Necessity	Submit cephalometric, panoramic films and photos, age and history of orthodontic treatment. Fax to Dental Review @ 425-918-5956
21208	Osteoplasty, facial bones; augmentation (autograft, allograft, or prosthetic implant)	Pre-Service Review Required	Medical Necessity	Submit cephalometric, panoramic films and photos, age and history of orthodontic treatment. Fax to Dental Review @ 425-918-5956
21209	Osteoplasty, facial bones; reduction	Pre-Service Review Required	Medical Necessity	Submit cephalometric, panoramic films and photos, age and history of orthodontic treatment. Fax to Dental Review @ 425-918-5956
21210	Graft, bone; nasal, maxillary or malar areas (includes obtaining graft)	Prior Authorization Required	Medical Necessity	Beginning 1/1/22 will only require review for WA members when submitted for gender transition/affirmation surgery. Submit history and physical, documentation of medical necessity and procedure report.
21240	Arthroplasty, temporomandibular joint, with or without autograft (includes obtaining graft)	Pre-Service Review Required	Medical Necessity	Submit diagnosis, prognosis and chart notes including history of non-invasive or non-surgical attempts to treat the TMJ. Fax to Dental Review @ 425-918-5956
21242	Arthroplasty, temporomandibular joint, with allograft	Pre-Service Review Required	Medical Necessity	Submit diagnosis, prognosis and chart notes including history of non-invasive or non-surgical attempts to treat the TMJ. Fax to Dental Review @ 425-918-5956

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
21243	Arthroplasty, temporomandibular joint, with prosthetic joint replacement	Pre-Service Review Required	Medical Necessity	MDs fax to IHM at 800-843-1114; DDS or DMDs: Complete the Dental Prior Authorization form found at: https://www.premera.com/documents/030000.pdf and FAX completed form to Dental Review at 425-918-5956 for review. DDS & DMD: Submit diagnosis, prognosis and chart notes including history of non-invasive or non-surgical attempts to treat the TMJ
21247	Reconstruction of mandibular condyle with bone and cartilage autografts (includes obtaining grafts) (eg, for hemifacial microsomia)	Pre-Service Review Required	Medical Necessity	Submit diagnosis, prognosis and chart notes including history of non-invasive or non-surgical attempts to treat the TMJ. Fax to Dental Review @ 425-918-5956
21270	Malar augmentation, prosthetic material	Pre-Service Review Required	Medical Necessity	Submit cephalometric, panoramic films and photos, age and history of orthodontic treatment. Fax to Dental Review @ 425-918-5956
21280	Medial canthopexy (separate procedure)	Prior Authorization Required	Cosmetic - Reconstructive	History and Physical, documentation of medical necessity and visual field
21282	Lateral canthopexy	Prior Authorization Required	Cosmetic - Reconstructive	History and Physical, documentation of medical necessity and visual field
21295	Reduction of masseter muscle and bone (eg, for treatment of benign masseteric hypertrophy); extraoral approach	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, procedure report.
21296	Reduction of masseter muscle and bone (eg, for treatment of benign masseteric hypertrophy); intraoral approach	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, procedure report.
21299	Unlisted craniofacial and maxillofacial procedure	Pre-Service Review Required	Medical Necessity	Submit Pre Operative Evaluation, History and Physical, and Operative report. If dental fax to Dental Review @ 425-918-5956

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
21480	Closed treatment of temporomandibular dislocation; initial or subsequent	Pre-Service Review Required	Medical Necessity	Submit diagnosis, prognosis and chart notes including history of non-invasive or non-surgical attempts to treat the TMJ. Fax to Dental Review @ 425-918-5956
21485	Closed treatment of temporomandibular dislocation; complicated (eg, recurrent requiring intermaxillary fixation or splinting), initial or subsequent	Pre-Service Review Required	Medical Necessity	Submit diagnosis, prognosis and chart notes including history of non-invasive or non-surgical attempts to treat the TMJ. Fax to Dental Review @ 425-918-5956
21490	Open treatment of temporomandibular dislocation	Pre-Service Review Required	Medical Necessity	Submit diagnosis, prognosis and chart notes including history of non-invasive or non-surgical attempts to treat the TMJ. Fax to Dental Review @ 425-918-5956
21499	Unlisted musculoskeletal procedure, head	Medical necessity review will be performed upon claims submission with supporting documentation.	Medical Necessity	Review required at claims submission; submit description of procedure with supporting documentation (including operative report if surgical) only for the date of service performed.
21685	Hyoid myotomy and suspension	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity and procedure report.
21899	Unlisted procedure, neck or thorax	Medical necessity review will be performed upon claims submission with supporting documentation.	Medical Necessity	Review required at claims submission; submit description of procedure with supporting documentation (including operative report if surgical) only for the date of service performed.
22510	Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection, inclusive of all imaging guidance; cervicothoracic	Prior Authorization Required	Medical Necessity	Submit History and Physical, documentation of medical necessity, operative report

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
22511	Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection, inclusive of all imaging guidance; lumbosacral	Prior Authorization Required	Medical Necessity	Submit History and Physical, documentation of medical necessity, operative report
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 Required	Medical Necessity	Submit History and Physical, documentation of medical necessity, operative report
22513	Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device (eg, kyphoplasty), 1 vertebral body, unilateral or bilateral cannulation, inclusive of all imaging guidance; thoracic	Prior Authorization Required	Medical Necessity	Submit History and Physical, documentation of medical necessity, operative report
22514	Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device (eg, kyphoplasty), 1 vertebral body, unilateral or bilateral cannulation, inclusive of all imaging guidance; lumbar	Prior Authorization Required	Medical Necessity	Submit History and Physical, documentation of medical necessity, operative report

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
22515	Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device (eg, kyphoplasty), 1 vertebral body, unilateral or bilateral cannulation, inclusive of all imaging guidance; each additional thoracic or lumbar vertebral body (List separately in addition to code for primary procedure	Prior Authorization Required	Medical Necessity	Submit History and Physical, documentation of medical necessity, operative report
22526	Percutaneous intradiscal electrothermal annuloplasty, unilateral or bilateral including fluoroscopic guidance; single level	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
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)	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
22533	Arthrodesis, lateral extracavitary technique, including minimal discectomy to prepare interspace (other than for decompression); lumbar	Prior Authorization Required	Medical necessity including site of service	Submit recent history and physical, plan of care, and documentation of medical necessity including for site of service. No review needed for member age 18 and under.
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 Required	Medical Necessity	Submit History and Physical, documentation of medical necessity including operative report. No review needed for member age 18 and under.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
22551	Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophytectomy and decompression of spinal cord and/or nerve roots; cervical below C2	Prior Authorization Required	Medical necessity including site of service	Submit recent history and physical, plan of care, and documentation of medical necessity including for site of service. No review needed for members under age 18.
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 Required	Medical Necessity	Submit History and Physical, documentation of medical necessity, operative report. No review needed for members under age 18.
22554	Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); cervical below C2	Prior Authorization Required	Medical necessity including site of service	Submit recent history and physical, plan of care, and documentation of medical necessity including for site of service. No review needed for members under age 18.
22558	Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); lumbar	Prior Authorization Required	Medical necessity including site of service	Submit recent history and physical, plan of care, and documentation of medical necessity including for site of service. No review needed for member age 18 and under.
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 Required	Medical Necessity	Submit History and Physical, documentation of medical necessity, operative report. No review needed for member age 18 and under.
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 Required	Investigative	Submit history and physical, documentation of medical necessity and procedure report.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
22600	Arthrodesis, posterior or posterolateral technique, single level; cervical below C2 segment	Prior Authorization Required	Medical necessity including site of service	Submit recent history and physical, plan of care, and documentation of medical necessity including for site of service. No review needed for members under age 18.
22612	Arthrodesis, posterior or posterolateral technique, single level; lumbar (with or without lateral transverse technique)	Prior Authorization Required	Medical necessity including site of service	Submit recent history and physical, plan of care, and documentation of medical necessity including for site of service. No review needed for member age 18 and under.
22614	Arthrodesis, posterior or posterolateral technique, single level; each additional vertebral segment (List separately in addition to code for primary procedure)	Prior Authorization Required	Medical Necessity	Submit History and Physical, documentation of medical necessity, operative report. No review needed for member age 18 and under.
22630	Arthrodesis, posterior interbody technique, including laminectomy and/or discectomy to prepare interspace (other than for decompression), single interspace; lumbar	Prior Authorization Required	Medical necessity including site of service	Submit recent history and physical, plan of care, and documentation of medical necessity including for site of service. No review needed for member age 18 and under.
22632	Arthrodesis, posterior interbody technique, including laminectomy and/or discectomy to prepare interspace (other than for decompression), single interspace; each additional interspace	Prior Authorization Required	Medical Necessity	Submit History and Physical, operative report, medical necessity documentation. No review needed for member age 18 and under.
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 and segment; lumbar	Prior Authorization Required	Medical necessity including site of service	Submit recent history and physical, plan of care, and documentation of medical necessity including for site of service. No review needed for member age 18 and under.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
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 and segment; each additional	Prior Authorization Required	Medical Necessity	History and Physical, operative report, documentation of conservative measures. No review needed for member age 18 and under.
22800	Arthrodesis, posterior, for spinal deformity, with or without cast; up to 6 vertebral segments	Prior Authorization Required	Medical Necessity	Submit History and Physical, documentation of medical necessity including operative report. No review needed for member age 18 and under.
22802	Arthrodesis, posterior, for spinal deformity, with or without cast; 7 to 12 vertebral segments	Prior Authorization Required	Medical Necessity	Submit History and Physical, documentation of medical necessity including operative report. No review needed for member age 18 and under.
22804	Arthrodesis, posterior, for spinal deformity, with or without cast; 13 or more vertebral segments	Prior Authorization Required	Medical Necessity	Submit History and Physical, documentation of medical necessity including operative report. No review needed for member age 18 and under.
22808	Arthrodesis, anterior, for spinal deformity, with or without cast; 2 to 3 vertebral segments	Prior Authorization Required	Medical Necessity	Submit History and Physical, documentation of medical necessity including operative report. No review needed for member age 18 and under.
22810	Arthrodesis, anterior, for spinal deformity, with or without cast; 4 to 7 vertebral segments	Prior Authorization Required	Medical Necessity	Submit History and Physical, documentation of medical necessity including operative report. No review needed for member age 18 and under.
22812	Arthrodesis, anterior, for spinal deformity, with or without cast; 8 or more vertebral segments	Prior Authorization Required	Medical Necessity	Submit History and Physical, documentation of medical necessity including operative report. No review needed for member age 18 and under.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
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 Required	Medical necessity including site of service	Submit recent history and physical, plan of care, and documentation of medical necessity including for site of service.
22857	Total disc arthroplasty (artificial disc), anterior approach, including discectomy to prepare interspace (other than for decompression); single interspace, lumbar	Prior Authorization Required	Investigative	Submit history and physical, documentation of medical necessity and procedure report.
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 Required	Medical necessity including site of service	Submit recent history and physical, plan of care, and documentation of medical necessity including for site of service.
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 Required	Investigative	Submit history and physical, documentation of medical necessity and procedure report.
22861	Revision including replacement of total disc arthroplasty (artificial disc), anterior approach, single interspace; cervical	Prior Authorization Required	Medical necessity including site of service	Submit recent history and physical, plan of care, and documentation of medical necessity including for site of service.
22862	Revision including replacement of total disc arthroplasty (artificial disc), anterior approach, single interspace; lumbar	Prior Authorization Required	Investigative	Submit history and physical, documentation of medical necessity and procedure report.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
22865	Removal of total disc arthroplasty (artificial disc), anterior approach, single interspace; lumbar	Prior Authorization Required	Investigative	Submit history and physical, documentation of medical necessity and procedure report.
22867	Insertion of interlaminar/interspinous process stabilization/distraction device, without fusion, including image guidance when performed, with open decompression, lumbar; single level	Prior Authorization Required	Investigative	Submit history and physical, documentation of medical necessity and procedure report.
22868	Insertion of interlaminar/interspinous process stabilization/distraction device, without fusion, including image guidance when performed, with open decompression, lumbar; second level	Prior Authorization Required	Investigative	Submit history and physical, documentation of medical necessity and procedure report.
22869	Insertion of interlaminar/interspinous process stabilization/distraction device, without open decompression or fusion, including image guidance when performed, lumbar; single level	Prior Authorization Required	Investigative	Submit history and physical, documentation of medical necessity and procedure report.
22870	Insertion of interlaminar/interspinous process stabilization/distraction device, without open decompression or fusion, including image guidance when performed, lumbar; second level	Prior Authorization Required	Investigative	Submit history and physical, documentation of medical necessity and procedure report.
22899	Unlisted procedure, spine	Medical necessity review will be performed upon claims submission with supporting documentation.	Medical Necessity	Review required at claims submission; submit description of procedure with supporting documentation (including operative report if surgical) only for the date of service performed.
22999	Unlisted procedure, abdomen, musculoskeletal system	Medical necessity review will be performed upon claims submission with supporting documentation.	Medical Necessity	Review required at claims submission; submit description of procedure with supporting documentation (including operative report if surgical) only for the date of service performed.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
23470	Arthroplasty, glenohumeral joint; hemiarthroplasty	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity and procedure report.
23472	Arthroplasty, glenohumeral joint; total shoulder (glenoid and proximal humeral replacement (eg, total shoulder))	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity and procedure report.
23473	Revision of total shoulder arthroplasty, including allograft when performed; humeral or glenoid component	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity and procedure report.
23474	Revision of total shoulder arthroplasty, including allograft when performed; humeral and glenoid component	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity and procedure report.
23929	Unlisted procedure, shoulder	Medical necessity review will be performed upon claims submission with supporting documentation.	Medical Necessity	Review required at claims submission; submit description of procedure with supporting documentation (including operative report if surgical) only for the date of service performed.
24999	Unlisted procedure, humerus or elbow	Medical necessity review will be performed upon claims submission with supporting documentation.	Medical Necessity	Review required at claims submission; submit description of procedure with supporting documentation (including operative report if surgical) only for the date of service performed.
25999	Unlisted procedure, forearm or wrist	Medical necessity review will be performed upon claims submission with supporting documentation.	Medical Necessity	Review required at claims submission; submit description of procedure with supporting documentation (including operative report if surgical) only for the date of service performed.
26989	Unlisted procedure, hands or fingers	Medical necessity review will be performed upon claims submission with supporting documentation.	Medical Necessity	Review required at claims submission; submit description of procedure with supporting documentation (including operative report if surgical) only for the date of service performed.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
27130	Arthroplasty, acetabular and proximal femoral prosthetic replacement (total hip arthroplasty), with or without autograft or allograft	Prior Authorization Required	Medical Necessity	Submit history and physical, procedure report and documentation of medical necessity. No review needed for members under age 18.
27132	Conversion of previous hip surgery to total hip arthroplasty, with or without autograft or allograft	Prior Authorization Required	Medical Necessity	Submit history and physical, procedure report and documentation of medical necessity. No review needed for members under age 18.
27134	Revision of total hip arthroplasty; both components, with or without autograft or allograft	Prior Authorization Required	Medical Necessity	Submit history and physical, procedure report and documentation of medical necessity. No review needed for members under age 18.
27137	Revision of total hip arthroplasty; acetabular component only, with or without autograft or allograft	Prior Authorization Required	Medical Necessity	Submit history and physical, procedure report and documentation of medical necessity. No review needed for members under age 18.
27138	Revision of total hip arthroplasty; femoral component only, with or without allograft	Prior Authorization Required	Medical Necessity	Submit history and physical, procedure report and documentation of medical necessity. No review needed for members under age 18.
27278	Arthrodesis, sacroiliac joint, percutaneous, with image guidance, including placement of intra-articular implant(s) without placement of transfixation device	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
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 Required	Medical Necessity	History and physical, documentation of medical necessity, operative report.
27280	Arthrodesis, sacroiliac joint, open, includes obtaining bone graft, including instrumentation, when performed	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity and procedure report.

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27299	Unlisted procedure, pelvis or hip joint	Medical necessity review will be performed upon claims submission with supporting documentation.	Medical Necessity	Review required at claims submission; submit description of procedure with supporting documentation (including operative report if surgical) only for the date of service performed.
27412	Autologous chondrocyte implantation, knee	Prior Authorization Required	Medical necessity including site of service	Submit recent history and physical, plan of care, and documentation of medical necessity including for site of service.
27415	Osteochrondral allograft, knee, open	Prior Authorization Required	Medical necessity including site of service	Submit recent history and physical, plan of care, and documentation of medical necessity including for site of service.
27416	Osteochondral autograft(s), knee, open (eg, mosaicplasty) (includes harvesting of autograft[s])	Prior Authorization Required	Medical necessity including site of service	Submit recent history and physical, plan of care, and documentation of medical necessity including for site of service.
27440	Arthroplasty, knee, tibial plateau;	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
27442	Arthroplasty, femoral condyles or tibial plateau(s), knee;	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
27443	Arthroplasty, femoral condyles or tibial plateau(s), knee; with debridement and partial synovectomy	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
27445	Arthroplasty, knee, hinge prosthesis (eg, Walldius type)	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
27446	Arthroplasty, knee, condyle and plateau; medial OR lateral compartment	Prior Authorization Required	Medical Necessity	Submit History and Physical, pre-operative notes, operative report and all radiology reports. No review needed for member age 18 and under.
27447	Arthroplasty, knee, condyle and plateau; medial AND lateral compartments with or without patella resurfacing (total knee arthroplasty)	Prior Authorization Required	Medical Necessity	Submit History and Physical, pre-operation notes, operative report and all radiology reports. No review needed for members under age 18.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
27486	Revision of total knee arthroplasty, with or without allograft; 1 component	Prior Authorization Required	Medical Necessity	Submit History and Physical, pre-operation notes, operative report and all radiology reports. No review needed for member age 18 and under.
27487	Revision of total knee arthroplasty, with or without allograft; femoral and entire tibial component	Prior Authorization Required	Medical Necessity	Submit History and Physical, pre-operation notes, operative report and all radiology reports. No review needed for member age 18 and under.
27599	Unlisted procedure femur or knee	Medical necessity review will be performed upon claims submission with supporting documentation.	Medical Necessity	Review required at claims submission; submit description of procedure with supporting documentation (including operative report if surgical) only for the date of service performed.
27899	Unlisted procedure, leg or ankle	Medical necessity review will be performed upon claims submission with supporting documentation.	Medical Necessity	Review required at claims submission; submit description of procedure with supporting documentation (including operative report if surgical) only for the date of service performed.
28446	Open osteochondral autograft, talus (includes obtaining graft[s])	Prior Authorization Required	Medical necessity including site of service	Submit recent history and physical, plan of care, and documentation of medical necessity including for site of service.
28890	Extracorporeal shock wave, high energy, performed by a physician, requiring anesthesia other than local, including ultrasound guidance, involving the plantar fascia	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
28899	Unlisted procedure, foot or toes	Medical necessity review will be performed upon claims submission with supporting documentation.	Medical Necessity	Review required at claims submission; submit description of procedure with supporting documentation (including operative report if surgical) only for the date of service performed.

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29799	Unlisted procedure, casting or strapping	Medical necessity review will be performed upon claims submission with supporting documentation.	Medical Necessity	Review required at claims submission; submit description of procedure with supporting documentation (including operative report if surgical) only for the date of service performed.
29800	Arthroscopy, temporomandibular joint, diagnostic, with or without synovial biopsy (separate procedure)	Pre-Service Review Required	Medical Necessity	Submit diagnosis, prognosis and chart notes including history of non-invasive or non-surgical attempts to treat the TMJ. Fax to Dental Review @ 425-918-5956
29804	Arthroscopy, temporomandibular joint, surgical	Pre-Service Review Required	Medical Necessity	Submit diagnosis, prognosis and chart notes including history of non-invasive or non-surgical attempts to treat the TMJ. Fax to Dental Review @ 425-918-5956
29848	Endoscopy, wrist, surgical, with release of transverse carpal ligament	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity and procedure report.
29866	Arthroscopy, knee, surgical; osteochondral autograft(s) (eg, mosaicplasty) (includes harvesting of the autograft[s])	Prior Authorization Required	Medical necessity including site of service	Submit recent history and physical, plan of care, and documentation of medical necessity including for site of service.
29867	Arthroscopy, knee, surgical; osteochrondral allograft(s)	Prior Authorization Required	Medical necessity including site of service	Submit site of service, history and physical, medical necessity documentation, operative report.
29868	Arthroscopy, knee, surgical; meniscal transplantation, medial or lateral	Pre-Service Review Required	Medical Necessity	Pre Operative Evaluation, History and Physical, and Operative report.
29870	Arthroscopy, knee, diagnostic, with or without synovial biopsy (separate procedure)	Prior Authorization Required	Medical Necessity	Submit History and Physical, documentation of medical necessity including procedure report. No review needed for member age 18 and under.

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29871	Arthroscopy, knee, surgical; for infection, lavage and drainage	Prior Authorization Required	Medical necessity including site of service	Submit Site of Service, history and Physical, medical necessity documentation including operative report. No review needed for member age 18 and under.
29873	Arthroscopy, knee, surgical; with lateral release	Prior Authorization Required	Medical necessity including site of service	Submit site of service, history and physical, documentation of medical necessity including procedure report. No review needed for member age 18 and under.
29874	Arthroscopy, knee, surgical; for removal of loose body or foreign body (eg, osteochondritis dissecans fragmentation, chondral fragmentation)	Prior Authorization Required	Medical necessity including site of service	Submit site of service, history and physical, documentation of medical necessity including procedure report. No review needed for member age 18 and under.
29875	Arthroscopy, knee, surgical; synovectomy, limited (eg, plica or shelf resection) (separate procedure)	Prior Authorization Required	Medical necessity including site of service	Submit site of service, history and physical, documentation of medical necessity including procedure report. No review needed for member age 18 and under.
29876	Arthroscopy, knee, surgical; synovectomy, major, 2 or more compartments (eg, medial or lateral)	Prior Authorization Required	Medical necessity including site of service	Submit site of service, history and physical, documentation of medical necessity including procedure report. No review needed for member age 18 and under.
29877	Arthroscopy, knee, surgical; debridement/shaving of articular cartilage (chondroplasty)	Prior Authorization Required	Medical necessity including site of service	Submit site of service, history and physical, documentation of medical necessity including procedure report. No review needed for member age 18 and under.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
29879	Arthroscopy, knee, surgical; abrasion arthroplasty (includes chondroplasty where necessary) or multiple drilling or microfracture	Prior Authorization Required	Medical necessity including site of service	Submit site of service, history and physical, documentation of medical necessity including procedure report. No review needed for member age 18 and under.
29880	Arthroscopy, knee, surgical; with meniscectomy (medial AND lateral, including any meniscal shaving)	Prior Authorization Required	Medical necessity including site of service	Submit site of service, history and physical, documentation of medical necessity including procedure report. No review needed for member age 18 and under.
29881	Arthroscopy, knee, surgical; with meniscectomy (medial OR lateral, including any meniscal shaving)	Prior Authorization Required	Medical necessity including site of service	Submit site of service, history and physical, documentation of medical necessity including procedure report. No review needed for member age 18 and under.
29882	Arthroscopy, knee, surgical; with meniscus repair (medial OR lateral)	Prior Authorization Required	Medical necessity including site of service	Submit site of service, history and physical, documentation of medical necessity including procedure report. No review needed for member age 18 and under.
29883	Arthroscopy, knee, surgical; with meniscus repair (medial AND lateral)	Prior Authorization Required	Medical necessity including site of service	Submit site of service, history and physical, documentation of medical necessity including procedure report. No review needed for member age 18 and under.
29884	Arthroscopy, knee, surgical; with lysis of adhesions, with or without manipulation (separate procedure)	Prior Authorization Required	Medical necessity including site of service	Submit site of service, history and physical, documentation of medical necessity including procedure report. No review needed for member age 18 and under.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
29888	Arthroscopically aided anterior cruciate ligament repair/augmentation or reconstruction	Prior Authorization Required	Medical necessity including site of service	Submit site of service, history and physical, documentation of medical necessity including procedure report. No review needed for member age 18 and under.
29889	Arthroscopically aided posterior cruciate ligament repair/augmentation or reconstruction	Prior Authorization Required	Medical necessity including site of service	Submit site of service, history and physical, documentation of medical necessity including procedure report. No review needed for member age 18 and under.
29914	Arthroscopy, hip, surgical; with femoroplasty (ie, treatment of cam lesion)	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
29915	Arthroscopy, hip, surgical; with acetabuloplasty (ie, treatment of pincer lesion)	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
29999	Unlisted procedure Arthroscopy	Medical necessity review will be performed upon claims submission with supporting documentation.	Medical Necessity	Review required at claims submission; submit description of procedure with supporting documentation (including operative report if surgical) only for the date of service performed.
30117	Excision or destruction (eg, laser), intranasal lesion; internal approach	Pre-Service Review Required	Investigative	Submit history and physical, documentation of medical necessity and procedure report.
30400	Rhinoplasty, primary; lateral and alar cartilages and/or elevation of nasal tip	Prior Authorization Required	Medical necessity including site of service	Submit site of service, pre operative evaluation, history and physical including functional impairment, and operative report.
30410	Rhinoplasty, primary; complete, external parts including bony pyramid, lateral and alar cartilages, and/or elevation of nasal tip	Prior Authorization Required	Medical necessity including site of service	Submit site of service, pre operative evaluation, history and physical including functional impairment, and operative report.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
30420	Rhinoplasty, primary; including major septal repair	Prior Authorization Required	Medical necessity including site of service	Submit site of service, pre operative evaluation, history and physical including functional impairment, and operative report.
30430	Rhinoplasty, secondary; minor revision (small amount of nasal tip work)	Prior Authorization Required	Medical necessity including site of service	Submit site of service, pre operative evaluation, history and physical including functional impairment, and operative report.
30435	Rhinoplasty, secondary; intermediate revision (bony work with osteotomies)	Prior Authorization Required	Medical necessity including site of service	Submit site of service, pre operative evaluation, history and physical including functional impairment, and operative report.
30450	Rhinoplasty, secondary; major revision (nasal tip work and osteotomies)	Prior Authorization Required	Medical necessity including site of service	Submit site of service, pre operative evaluation, history and physical including functional impairment, and operative report.
30468	Repair of nasal valve collapse with subcutaneous/submucosal lateral wall implant(s)	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
30469	Repair of nasal valve collapse with low energy, temperature-controlled (ie, radiofrequency) subcutaneous/submucosal remodeling	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
30999	Unlisted procedure, nose	Medical necessity review will be performed upon claims submission with supporting documentation.	Medical Necessity	Review required at claims submission; submit description of procedure with supporting documentation (including operative report if surgical) only for the date of service performed.
3101	Adult Care - Adult Day Care, Medical and Social - Hourly	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
3102	Adult Care - Adult Day Care, Social - Hourly	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
3103	Adult Care - Medical and Social - Daily	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.

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3104	Adult Care - Social - Daily	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
3105	Adult Foster Care - Daily	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
3109	Other Adult Care	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
31233	Nasal/sinus endoscopy, diagnostic; with maxillary sinusoscopy (via inferior meatus or canine fossa puncture)	Prior Authorization Required	Medical necessity including site of service	Submit recent history and physical, plan of care, and documentation of medical necessity including for site of service.
31235	Nasal/sinus endoscopy, diagnostic; with sphenoid sinusoscopy (via puncture of sphenoidal face or cannulation of ostium)	Prior Authorization Required	Medical necessity including site of service	Submit recent history and physical, plan of care, and documentation of medical necessity including for site of service.
31240	Nasal/sinus endoscopy, surgical; with concha bullosa resection	Prior Authorization Required	Medical necessity including site of service	Submit recent history and physical, plan of care, and documentation of medical necessity including for site of service.
31242	Nasal/sinus endoscopy, surgical; with destruction by radiofrequency ablation, posterior nasal nerve	Pre-Service Review Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
31243	Nasal/sinus endoscopy, surgical; with destruction by cryoablation, posterior nasal nerve	Pre-Service Review Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
31253	Nasal/sinus endoscopy, surgical with ethmoidectomy; total (anterior and posterior), including frontal sinus exploration, with removal of tissue from frontal sinus, when performed	Prior Authorization Required	Medical necessity including site of service	Submit Site of Service, Pre-Operative Evaluation, History and Physical and Operative report. No review needed for member age 18 and under.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
31254	Nasal/sinus endoscopy, surgical; with ethmoidectomy, partial (anterior)	Prior Authorization Required	Medical necessity including site of service	Submit Site of Service, History and Physical including functional impairment, pre- operative evaluation, imaging and operative reports. No review needed for member age 18 and under.
31255	Nasal/sinus endoscopy, surgical; with ethmoidectomy, total (anterior and posterior)	Prior Authorization Required	Medical necessity including site of service	Submit Site of Service, History and Physical including functional impairment, pre- operative evaluation, imaging and operative reports. No review needed for member age 18 and under.
31256	Nasal/sinus endoscopy, surgical, with maxillary antrostomy;	Prior Authorization Required	Medical necessity including site of service	Submit Site of Service, History and Physical including functional impairment, pre- operative evaluation, imaging and operative reports. No review needed for member age 18 and under.
31257	Nasal/sinus endoscopy, surgical with ethmoidectomy; total (anterior and posterior), including sphenoidotomy	Prior Authorization Required	Medical necessity including site of service	Submit Site of Service, Pre-Operative Evaluation, History and Physical and Operative report. No review needed for member age 18 and under.
31259	Nasal/sinus endoscopy, surgical with ethmoidectomy; total (anterior and posterior), including sphenoidotomy, with removal of tissue from the sphenoid sinus	Prior Authorization Required	Medical necessity including site of service	Submit Site of Service, Pre-Operative Evaluation, History and Physical and Operative report. No review needed for member age 18 and under.
31267	Nasal/sinus endoscopy, surgical, with maxillary antrostomy; with removal of tissue from maxillary sinus	Prior Authorization Required	Medical necessity including site of service	Submit Site of Service, History and Physical including functional impairment, pre- operative evaluation, imaging and operative reports. No review needed for member age 18 and under.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
31276	Nasal/sinus endoscopy, surgical with frontal sinus exploration, with or without removal of tissue from frontal sinus	Prior Authorization Required	Medical necessity including site of service	Submit Site of Service, History and Physical including functional impairment, pre- operative evaluation, imaging and operative reports. No review needed for member age 18 and under.
31287	Nasal/sinus endoscopy, surgical, with sphenoidotomy;	Prior Authorization Required	Medical necessity including site of service	Submit Site of Service, History and Physical including functional impairment, pre- operative evaluation, imaging and operative reports. No review needed for member age 18 and under.
31288	Nasal/sinus endoscopy, surgical, with sphenoidotomy; with removal of tissue from the sphenoid sinus	Prior Authorization Required	Medical necessity including site of service	Submit Site of Service, History and Physical including functional impairment, pre- operative evaluation, imaging and operative reports. No review needed for member age 18 and under.
31295	Nasal/sinus endoscopy, surgical, with dilation (eg, balloon dilation); maxillary sinus ostium transnasal or via canine fossa	Prior Authorization Required	Medical necessity including site of service	Submit Site of Service, Pre Operative Evaluation, History and Physical and Operative report. No review needed for member age 18 and under.
31296	Nasal/sinus endoscopy, surgical, with dilation (eg, balloon dilation); frontal sinus ostium	Prior Authorization Required	Medical necessity including site of service	Submit Site of Service, Pre Operative Evaluation, History and Physical, and Operative report. No review needed for member age 18 and under.
31297	Nasal/sinus endoscopy, surgical, with dilation (eg, balloon dilation) sphenoid sinus ostium	Prior Authorization Required	Medical necessity including site of service	Submit recent history and physical, plan of care, and documentation of medical necessity including for site of service. No review needed for member age 18 and under.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
31298	Nasal/sinus endoscopy, surgical, with dilation (eg, balloon dilation) frontal and sphenoid sinus ostia	Prior Authorization Required	Medical necessity including site of service	Submit Site of Service, Pre-Operative Evaluation, History and Physical and Operative report. No review needed for member age 18 and under.
31299	Unlisted procedure, accessory sinuses	Medical necessity review will be performed upon claims submission with supporting documentation.	Medical Necessity	Review required at claims submission; submit description of procedure with supporting documentation (including operative report if surgical) only for the date of service performed.
31599	Unlisted procedure, larynx	Medical necessity review will be performed upon claims submission with supporting documentation.	Medical Necessity	Review required at claims submission; submit description of procedure with supporting documentation (including operative report if surgical) only for the date of service performed.
31643	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with placement of catheter(s) for intracavitary radioelement application	Prior Authorization Required	Radiation Oncology	No review for non-cancer diagnoses. FOR CANCER DIAGNOSES ONLY: Submit online review with Carelon at www.providerportal.com. For prior authorization include history and physical, results of previous diagnostics procedure report.
31647	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with balloon occlusion, when performed, assessment of air leak, airway sizing, and insertion of bronchial valve(s), initial lobe	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
31648	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with removal of bronchial valve(s), initial lobe	Possible Denial; Medical Records Optional	Investigative	Documentation optional.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
31649	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with removal of bronchial valve(s), each additional lobe (List separately in addition to code for primary procedure)	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
31651	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with balloon occlusion, when performed, assessment of air leak, airway sizing, and insertion of bronchial valve(s), each additional lobe (List separately in addition to code for primary procedure[s])	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
31899	Unlisted procedure, trachea, bronchi	Medical necessity review will be performed upon claims submission with supporting documentation.	Medical Necessity	Review required at claims submission; submit description of procedure with supporting documentation (including operative report if surgical) only for the date of service performed.
32664	Thoracoscopy, surgical; with thoracic sympathectomy	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
32701	Thoracic target(s) delineation for stereotactic body radiation therapy (SRS/SBRT), (photon or particle beam), entire course of treatment	Prior Authorization Required	Radiation Oncology	No review for non-cancer diagnoses. FOR CANCER DIAGNOSES ONLY: Submit online review with Carelon at www.providerportal.com. For prior authorization include history and physical, results of previous diagnostics procedure report.
32851	Lung transplant, single; without cardiopulmonary bypass	Prior Authorization Required	Medical Necessity	Submit Transplant evaluation and facility acceptance letter
32852	Lung transplant, single; with cardiopulmonary bypass	Prior Authorization Required	Medical Necessity	Submit Transplant evaluation and facility acceptance letter
32853	Lung transplant, double (bilateral sequential or en bloc); without cardiopulmonary bypass	Prior Authorization Required	Medical Necessity	Submit Transplant evaluation and facility acceptance letter

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
32854	Lung transplant, double (bilateral sequential or en bloc); with cardiopulmonary bypass	Prior Authorization Required	Medical Necessity	Submit Transplant evaluation and facility acceptance letter
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 Required	Medical Necessity	Submit history and physical, documentation of medical necessity and procedure report.
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 Required	Medical Necessity	Submit history and physical, documentation of medical necessity and procedure report.
32999	Unlisted procedure, lungs and pleura	Medical necessity review will be performed upon claims submission with supporting documentation.	Medical Necessity	Review required at claims submission; submit description of procedure with supporting documentation (including operative report if surgical) only for the date of service performed.
33254	Operative tissue ablation and reconstruction of atria, limited (eg, modified maze procedure)	Prior Authorization Required	Investigative	Submit history and physical, documentation of medical necessity.
33255	Operative tissue ablation and reconstruction of atria, extensive (eg, maze procedure); without cardiopulmonary bypass	Prior Authorization Required	Investigative	Submit history and physical, documentation of medical necessity.
33256	Operative tissue ablation and reconstruction of atria, extensive (eg, maze procedure); with cardiopulmonary bypass	Prior Authorization Required	Investigative	Submit history and physical, documentation of medical necessity.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
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 Required	Investigative	Submit history and physical, documentation of medical necessity.
33265	Endoscopy, surgical; operative tissue ablation and reconstruction of atria, limited (eg, modified maze procedure), without cardiopulmonary bypass	Prior Authorization Required	Investigative	Submit history and physical, documentation of medical necessity.
33266	Endoscopy, surgical; operative tissue ablation and reconstruction of atria, extensive (eg, maze procedure), without cardiopulmonary bypass	Prior Authorization Required	Investigative	Submit history and physical, documentation of medical necessity.
33267	Exclusion of left atrial appendage, open, any method (eg, excision, isolation via stapling, oversewing, ligation, plication, clip)	Pre-Service Review Required	Investigative	Submit history and physical, documentation of medical necessity.
33268	Exclusion of left atrial appendage, open, performed at the time of other sternotomy or thoracotomy procedure(s), any method (eg, excision, isolation via stapling, oversewing, ligation, plication, clip) (List separately in addition to code for primary procedure)	Pre-Service Review Required	Investigative	Submit history and physical, documentation of medical necessity.
33269	Exclusion of left atrial appendage, thoracoscopic, any method (eg, excision, isolation via stapling, oversewing, ligation, plication, clip)	Pre-Service Review Required	Investigative	Submit history and physical, documentation of medical necessity.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
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 Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
33289	Transcatheter implantation of wireless pulmonary artery pressure sensor for long-term hemodynamic monitoring, including deployment and calibration of the sensor, right heart	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
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 Required	Medical Necessity	Submit History and Physical, documentation of medical necessity, operative report
33361	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; percutaneous femoral artery approach	Prior Authorization Required	Medical Necessity	History and Physical, procedure report
33362	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; open femoral artery approach	Prior Authorization Required	Medical Necessity	History and Physical, procedure report
33363	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; open axillary artery approach	Prior Authorization Required	Medical Necessity	History and Physical, procedure report
33364	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; open iliac artery approach	Prior Authorization Required	Medical Necessity	History and Physical, procedure report

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
33365	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; transaortic approach (eg, median sternotomy, mediastinotomy)	Prior Authorization Required	Medical Necessity	History and Physical, procedure report
33366	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; transapical exposure (eg, left thoracotomy)	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, operative report.
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)	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
33418	Transcatheter mitral valve repair, percutaneous approach, including transseptal puncture when performed; initial prosthesis	Prior Authorization Required	Medical Necessity	Submit History and Physical, documentation of medical necessity, operative report
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 Required	Medical Necessity	Submit History and Physical, documentation of medical necessity, operative report
33477	Transcatheter pulmonary valve implantation, percutaneous approach, including pre-stenting of the valve delivery site, when performed	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity and procedure report.
33927	Implantation of a total replacement heart system (artificial heart) with recipient cardiectomy	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity and procedure report.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
33928	Removal and replacement of total replacement heart system (artificial heart)	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity and procedure report.
33929	Removal of a total replacement heart system (artificial heart) for heart transplantation (List separately in addition to code for primary procedure)	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity and procedure report.
33935	Heart-lung transplant with recipient cardiectomy- pneumonectomy	Prior Authorization Required	Medical Necessity	Submit Transplant evaluation and facility acceptance letter
33945	Heart transplant, with or without recipient cardiectomy	Prior Authorization Required	Medical Necessity	Submit Transplant evaluation and facility acceptance letter
33975	Insertion of ventricular assist device; extracorporeal, single ventricle	Prior Authorization Required	Medical Necessity	Submit History and Physical, documentation of medical necessity, operative report
33976	Insertion of ventricular assist device; extracorporeal, biventricular	Prior Authorization Required	Medical Necessity	Submit History and Physical, documentation of medical necessity, operative report
33979	Insertion of ventricular assist device implantable intracorporeal single ventricle	Prior Authorization Required	Medical Necessity	Submit History and Physical, documentation of medical necessity, operative report
33981	Replacement of extracorporeal ventricular assist device, single or biventricular, pump(s), single or each pump	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity and procedure report.
33982	Replacement of ventricular assist device pump(s); implantable intracorporeal, single ventricle, without cardiopulmonary bypass	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity and procedure report.
33983	Replacement of ventricular assist device pump(s); implantable intracorporeal, single ventricle, with cardiopulmonary bypass	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity and procedure report.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
33990	Insertion of ventricular assist device, percutaneous, including radiological supervision and interpretation; left heart, arterial access only	Pre-Service Review Required	Investigative	Submit history and physical, documentation of medical necessity and procedure report.
33991	Insertion of ventricular assist device, percutaneous, including radiological supervision and interpretation; left heart, both arterial and venous access, with transseptal puncture	Pre-Service Review Required	Investigative	Submit history and physical, documentation of medical necessity and procedure report.
33992	Removal of percutaneous left heart ventricular assist device, arterial or arterial and venous cannula(s), at separate and distinct session from insertion	Pre-Service Review Required	Investigative	Submit history and physical, documentation of medical necessity and procedure report.
33993	Repositioning of percutaneous right or left heart ventricular assist device with imaging guidance at separate and distinct session from insertion	Pre-Service Review Required	Investigative	Submit history and physical, documentation of medical necessity and procedure report.
33995	Insertion of ventricular assist device, percutaneous, including radiological supervision and interpretation; right heart, venous access only	Pre-Service Review Required	Investigative	Submit history and physical, documentation of medical necessity and procedure report.
33997	Removal of percutaneous right heart ventricular assist device, venous cannula, at separate and distinct session from insertion	Pre-Service Review Required	Investigative	Submit history and physical, documentation of medical necessity and procedure report.
33999	Unlisted procedure, cardiac surgery	Medical necessity review will be performed upon claims submission with supporting documentation.	Medical Necessity	Review required at claims submission; submit description of procedure with supporting documentation (including operative report if surgical) only for the date of service performed.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
36299	Unlisted procedure, vascular injection	Medical necessity review will be performed upon claims submission with supporting documentation.	Medical Necessity	Review required at claims submission; submit description of procedure with supporting documentation (including operative report if surgical) only for the date of service performed.
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 Required	Medical Necessity	Submit pre-Operative Evaluation, History and Physical including results of Doppler studies, and Operative report.
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 Required	Medical Necessity	Submit pre-Operative Evaluation, History and Physical including results of Doppler studies, and Operative report.
36468	Single or multiple injections of sclerosing solutions, spider veins (telangiectasia); limb or trunk	Prior Authorization Required	Cosmetic	Pre-Operative Evaluation, History and Physical including functional impairment, and Operative report.
36470	Injection of sclerosing solution; single vein	Prior Authorization Required	Medical Necessity	Submit pre-Operative Evaluation, History and Physical including results of Doppler studies, and Operative report.
36471	Injection of sclerosing solution; multiple veins, same leg	Prior Authorization Required	Medical Necessity	Submit pre-Operative Evaluation, History and Physical including results of Doppler studies, and Operative report.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
36473	Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, mechanochemical; first vein treated	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
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	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
36475	Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, radiofrequency,; first vein treated	Prior Authorization Required	Medical Necessity	Submit pre-Operative Evaluation, History and Physical including results of Doppler studies, and Operative report.
36476	Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, radiofrequency; second and subsequent veins treated in a single extremity, each through separate access sites	Prior Authorization Required	Medical Necessity	Submit pre-Operative Evaluation, History and Physical including results of Doppler studies, and Operative report.
36478	Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, laser; first vein treated	Prior Authorization Required	Medical Necessity	Submit pre-Operative Evaluation, History and Physical including results of Doppler studies, and Operative report.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
36479	Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, laser; second and subsequent veins treated in a single extremity, each through separate access sites	Prior Authorization Required	Medical Necessity	Submit pre-Operative Evaluation, History and Physical including results of Doppler studies, and Operative report.
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 Required	Medical Necessity	Submit history and physical, documentation of medical necessity and procedure report.
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 Required	Medical Necessity	Submit history and physical, documentation of medical necessity and procedure report.
36511	Therapeutic apheresis; for white blood cells	Prior Authorization Required	Medical Necessity	Submit Transplant evaluation and facility acceptance letter
36522	Photopheresis, extracorporeal	Prior Authorization Required	Medical Necessity	History and Physical including condition being treated, related diagnostics, and procedure report
37220	Revascularization, endovascular, open or percutaneous, iliac artery, unilateral, initial vessel; with transluminal angioplasty	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity and procedure report.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
37221	Revascularization, endovascular, open or percutaneous, iliac artery, unilateral, initial vessel; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity and procedure report.
37222	Revascularization, endovascular, open or percutaneous, iliac artery, each additional ipsilateral iliac vessel; with transluminal angioplasty (List separately in addition to code for primary procedure)	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity and procedure report.
37223	Revascularization, endovascular, open or percutaneous, iliac artery, each additional ipsilateral iliac vessel; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed (List separately in addition to code for primary procedure)	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity and procedure report.
37224	Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with transluminal angioplasty	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity and procedure report.
37225	Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with atherectomy, includes angioplasty within the same vessel, when performed	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity and procedure report.
37226	Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity and procedure report.

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37227	Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with transluminal stent placement(s) and atherectomy, includes angioplasty within the same vessel, when performed	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity and procedure report.
37228	Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with transluminal angioplasty	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity and procedure report.
37229	Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with atherectomy, includes angioplasty within the same vessel, when performed	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity and procedure report.
37230	Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity and procedure report.
37231	Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with transluminal stent placement(s) and atherectomy, includes angioplasty within the same vessel, when performed	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity and procedure report.
37232	Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, each additional vessel; with transluminal angioplasty (List separately in addition to code for primary procedure)	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity and procedure report.

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37233	Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, each additional vessel; with atherectomy, includes angioplasty within the same vessel, when performed (List separately in addition to code for primary procedure)	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity and procedure report.
37234	Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, each additional vessel; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed (List separately in addition to code for primary procedure)	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity and procedure report.
37235	Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, each additional vessel; with transluminal stent placement(s) and atherectomy, includes angioplasty within the same vessel, when performed (List separately in addition to code for primary procedure)	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity and procedure report.
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 Required	Medical Necessity	Submit history and physical, documentation of medical necessity and procedure report.
37501	Unlisted vascular endoscopy procedure	Medical necessity review will be performed upon claims submission with supporting documentation.	Medical Necessity	Review required at claims submission; submit description of procedure with supporting documentation (including operative report if surgical) only for the date of service performed.

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37799	Unlisted procedure, vascular surgery	Medical necessity review will be performed upon claims submission with supporting documentation.	Medical Necessity	Review required at claims submission; submit description of procedure with supporting documentation (including operative report if surgical) only for the date of service performed.
38129	Unlisted laparoscopy procedure, spleen	Medical necessity review will be performed upon claims submission with supporting documentation.	Medical Necessity	Review required at claims submission; submit description of procedure with supporting documentation (including operative report if surgical) only for the date of service performed.
38228	Chimeric antigen receptor t-cell (car-t) therapy; car-t cell administration, autologous	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
38230	Bone marrow harvesting for transplantation; allogeneic	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
38232	Bone marrow harvesting for transplantation; autologous	Prior Authorization Required	Medical Necessity	Submit Transplant evaluation and facility acceptance letter
38240	Hematopoietic progenitor cell (HPC); allogeneic transplantation per donor	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
38241	Hematopoietic progenitor cell (HPC); autologous transplantation	Prior Authorization Required	Medical Necessity	Submit Transplant evaluation and facility acceptance letter
38589	Unlisted laparoscopy procedure, lymphatic system	Medical necessity review will be performed upon claims submission with supporting documentation.	Medical Necessity	Review required at claims submission; submit description of procedure with supporting documentation (including operative report if surgical) only for the date of service performed.
38999	Unlisted procedure, hemic or lymphatic system	Medical necessity review will be performed upon claims submission with supporting documentation.	Medical Necessity	Review required at claims submission; submit description of procedure with supporting documentation (including operative report if surgical) only for the date of service performed.

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39499	Unlisted procedure, mediastinum	Medical necessity review will be performed upon claims submission with supporting documentation.	Medical Necessity	Review required at claims submission; submit description of procedure with supporting documentation (including operative report if surgical) only for the date of service performed.
39599	Unlisted procedure, diaphragm	Medical necessity review will be performed upon claims submission with supporting documentation.	Medical Necessity	Review required at claims submission; submit description of procedure with supporting documentation (including operative report if surgical) only for the date of service performed.
40500	Vermilionectomy (lip shave), with mucosal advancement	Prior Authorization Required	Medical Necessity	Beginning 1/1/22 will only require review for WA members when submitted for gender transition/affirmation surgery. Submit history and physical, documentation of medical necessity and procedure report.
40510	Excision of lip; transverse wedge excision with primary closure	Prior Authorization Required	Medical Necessity	Beginning 1/1/22 will only require review for WA members when submitted for gender transition/affirmation surgery. Submit history and physical, documentation of medical necessity and procedure report.
40520	Excision of lip; V-excision with primary direct linear closure	Prior Authorization Required	Medical Necessity	Beginning 1/1/22 will only require review for WA members when submitted for gender transition/affirmation surgery. Submit history and physical, documentation of medical necessity and procedure report.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
40525	Excision of lip; full thickness, reconstruction with local flap (eg, Estlander or fan)	Prior Authorization Required	Medical Necessity	Beginning 1/1/22 will only require review for WA members when submitted for gender transition/affirmation surgery. Submit history and physical, documentation of medical necessity and procedure report.
40527	Excision of lip; full thickness, reconstruction with cross lip flap (Abbe-Estlander)	Prior Authorization Required	Medical Necessity	Beginning 1/1/22 will only require review for WA members when submitted for gender transition/affirmation surgery. Submit history and physical, documentation of medical necessity and procedure report.
40702	Plastic repair of cleft lip/nasal deformity; primary bilateral, 1 of 2 stages	Pre-Service Review Required	Medical Necessity	Submit cephalometric, panoramic films and photos, age and history of orthodontic treatment. Fax to Dental Review @ 425-918-5956
40799	Unlisted procedure, lips	Medical necessity review will be performed upon claims submission with supporting documentation.	Medical Necessity	Review required at claims submission; submit description of procedure with supporting documentation (including operative report if surgical) only for the date of service performed.
40899	Unlisted procedure, vestibule of mouth	Medical necessity review will be performed upon claims submission with supporting documentation.	Medical Necessity	Review required at claims submission; submit description of procedure with supporting documentation (including operative report if surgical) only for the date of service performed.

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41019	Placement of needles, catheters, or other device(s) into the head and/or neck region (percutaneous, transoral, or transnasal) for subsequent interstitial radioelement application	Prior Authorization Required	Radiation Oncology	No review for non-cancer diagnoses. FOR CANCER DIAGNOSES ONLY: Submit online review with Carelon at www.providerportal.com. For prior authorization include history and physical, results of previous diagnostics procedure report.
41512	Tongue base suspension, permanent suture technique	Prior Authorization Required	Investigative	Submit history and physical, documentation of medical necessity and procedure report.
41530	Submucosal ablation of the tongue base, radiofrequency, 1 or more sites, per session	Prior Authorization Required	Investigative	History and physical, including sleep study results, results of CPAP trial.
41599	Unlisted procedure, tongue, floor of mouth	Medical necessity review will be performed upon claims submission with supporting documentation.	Medical Necessity	Review required at claims submission; submit description of procedure with supporting documentation (including operative report if surgical) only for the date of service performed.
41899	Unlisted procedure, dentoalveolar structures	Medical necessity review will be performed upon claims submission with supporting documentation.	Medical Necessity	Review required at claims submission; submit description of procedure with supporting documentation (including operative report if surgical) only for the date of service performed.
42145	Palatopharyngoplasty (eg, uvulopalatopharyngoplasty, uvulopharyngoplasty)	Prior Authorization Required	Medical necessity including site of service	Submit Site of Service, history and physical, including sleep study results, results of CPAP trial. No review needed for member age 18 and under.
42299	Unlisted procedure, palate, uvula	Medical necessity review will be performed upon claims submission with supporting documentation.	Medical Necessity	Review required at claims submission; submit description of procedure with supporting documentation (including operative report if surgical) only for the date of service performed.

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42699	Unlisted procedure, salivary glands or ducts	Medical necessity review will be performed upon claims submission with supporting documentation.	Medical Necessity	Review required at claims submission; submit description of procedure with supporting documentation (including operative report if surgical) only for the date of service performed.
42950	Pharyngoplasty (plastic or reconstructive operation on pharynx)	Prior Authorization Required	Medical Necessity	Submit Site of Service, history and physical, including sleep study results, results of CPAP trial. No review needed for member age 18 and under.
42999	Unlisted procedure, pharynx, adenoids, or tonsils	Medical necessity review will be performed upon claims submission with supporting documentation.	Medical Necessity	Review required at claims submission; submit description of procedure with supporting documentation (including operative report if surgical) only for the date of service performed.
43201	Esophagoscopy, rigid or flexible; with directed submucosal injection(s), any substance	Prior Authorization Required	Investigative	Submit history and physical, documentation of medical necessity and procedure report.
43210	Esophagogastroduodenoscopy, flexible, transoral; with esophagogastric fundoplasty, partial or complete, includes duodenoscopy when performed	Prior Authorization Required	Investigative	Submit history and physical, documentation of medical necessity and procedure report.
43235	Esophagogastroduodenoscopy, flexible, transoral; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)	Prior Authorization Required	Medical Necessity	Submit History and Physical, procedure report. No review needed for member age 18 and under.
43236	Esophagogastroduodenoscopy, flexible, transoral; with directed submucosal injection(s), any substance	Prior Authorization Required	Investigative	Submit history and physical, documentation of medical necessity and procedure report.
43238	Esophagogastroduodenoscopy, flexible, transoral; with transendoscopic ultrasound-guided intramural or transmural fine needle aspiration/biopsy(s),	Prior Authorization Required	Medical Necessity	Submit History and Physical, procedure report. No review needed for member age 18 and under.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
43239	Esophagogastroduodenoscopy, flexible, transoral; with biopsy, single or multiple	Prior Authorization Required	Medical Necessity	Submit History and Physical, procedure report. No review needed for member age 18 and under.
43242	Esophagogastroduodenoscopy, flexible, transoral; with transendoscopic ultrasound-guided intramural or transmural fine needle aspiration/biopsy(s)	Prior Authorization Required	Medical Necessity	Submit History and Physical, procedure report. No review needed for member age 18 and under.
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 Required	Investigative	Submit history and physical, documentation of medical necessity and procedure report.
43284	Laparoscopy, surgical, esophageal sphincter augmentation procedure, placement of sphincter augmentation device (ie, magnetic band), including cruroplasty when performed	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
43285	Removal of esophageal sphincter augmentation device	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
43289	Unlisted laparoscopy procedure, esophagus	Medical necessity review will be performed upon claims submission with supporting documentation.	Medical Necessity	Review required at claims submission; submit description of procedure with supporting documentation (including operative report if surgical) only for the date of service performed.
43290	Esophagogastroduodenoscopy, flexible, transoral; with deployment of intragastric bariatric balloon	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
43291	Esophagogastroduodenoscopy, flexible, transoral; with removal of intragastric bariatric balloon(s)	Possible Denial; Medical Records Optional	Investigative	Documentation optional.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
43497	Lower esophageal myotomy, transoral (ie, peroral endoscopic myotomy [POEM])	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
43499	Unlisted procedure, esophagus	Medical necessity review will be performed upon claims submission with supporting documentation.	Medical Necessity	Review required at claims submission; submit description of procedure with supporting documentation (including operative report if surgical) only for the date of service performed.
43644	Laparoscopy, surgical, gastric restrictive procedure; with gastric bypass and Roux-en-Y gastroenterostomy	Prior Authorization Required	Obesity	Submit office evaluation including height and weight, treatment plan and documentation of procedure.
43645	Laparoscopy, surgical, gastric restrictive procedure; with gastric bypass small intestine reconstruction to limit absorption	Prior Authorization Required	Obesity	Submit office evaluation including height and weight, treatment plan and documentation of procedure.
43647	Laparoscopy, surgical; implantation or replacement of gastric neurostimulator electrodes, antrum	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity and procedure report.
43648	Laparoscopy, surgical; revision or removal of gastric neurostimulator electrodes, antrum	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity and procedure report.
43659	Unlisted laparoscopy procedure, stomach	Medical necessity review will be performed upon claims submission with supporting documentation.	Medical Necessity	Review required at claims submission; submit description of procedure with supporting documentation (including operative report if surgical) only for the date of service performed.
43770	Laparoscopy, surgical, gastric restrictive procedure; placement of adjustable gastric band (gastric band and subcutaneous port components	Prior Authorization Required	Obesity	Submit office evaluation including height and weight, treatment plan and documentation of procedure.
43771	Laparoscopy, surgical, gastric restrictive procedure; revision of adjustable gastric band component only	Prior Authorization Required	Obesity	Submit office evaluation including height and weight, treatment plan and documentation of procedure.

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43772	Laparoscopy, surgical, gastric restrictive procedure; removal of adjustable gastric band component only	Prior Authorization Required	Obesity	Submit office evaluation including height and weight, treatment plan and documentation of procedure.
43773	Laparoscopy, surgical, gastric restrictive procedure; removal and replacement of adjustable gastric band component only	Prior Authorization Required	Obesity	Submit office evaluation including height and weight, treatment plan and documentation of procedure.
43774	Laparoscopy, surgical, gastric restrictive procedure; removal of adjustable gastric band and subcutaneous port components	Prior Authorization Required	Obesity	Submit office evaluation including height and weight, treatment plan and documentation of procedure.
43775	Laparoscopy, surgical, gastric restrictive procedure; longitudinal gastrectomy (ie, sleeve gastrectomy)	Prior Authorization Required	Obesity	Submit office evaluation including height and weight, treatment plan and documentation of procedure.
43842	Gastric restrictive procedure, without gastric bypass, for morbid obesity; vertical-banded gastroplasty	Prior Authorization Required	Obesity	Submit office evaluation including height and weight, treatment plan and documentation of procedure.
43843	Gastric restrictive procedure, without gastric bypass, for morbid obesity; other than vertical-banded gastroplasty	Prior Authorization Required	Obesity	Submit office evaluation including height and weight, treatment plan and documentation of procedure.
43845	Gastric restrictive procedure with partial gastrectomy, pylorus-preserving duodenoileostomy and ileoileostomy	Prior Authorization Required	Obesity	Submit office evaluation including height and weight, treatment plan and documentation of procedure.
43846	Gastric restrictive procedure, with gastric bypass for morbid obesity; with short limb (150 cm or less) Roux-en-Y gastroenterostomy	Prior Authorization Required	Obesity	Submit office evaluation including height and weight, treatment plan, proposed procedure, operative report if procedure performed.
43847	Gastric restrictive procedure, with gastric bypass for morbid obesity; with small intestine reconstruction to limit absorption	Prior Authorization Required	Obesity	Submit office evaluation including height and weight, treatment plan, proposed procedure, operative report if procedure performed.
43848	Revision, open, of gastric restrictive procedure for morbid obesity, other than adjustable gastric restrictive device (separate procedure)	Prior Authorization Required	Obesity	Submit office evaluation including height and weight, treatment plan, proposed procedure, operative report if procedure performed.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
43881	Implantation or replacement of gastric neurostimulator electrodes, antrum, open	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity and procedure report.
43882	Revision or removal of gastric neurostimulator electrodes, antrum, open	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity and procedure report.
43886	Gastric restrictive procedure, open; revision of subcutaneous port component only	Prior Authorization Required	Obesity	Submit office evaluation including height and weight, treatment plan, proposed procedure, operative report if procedure performed.
43887	Gastric restrictive procedure, open; removal of subcutaneous port component only	Prior Authorization Required	Obesity	Submit office evaluation including height and weight, treatment plan, proposed procedure, operative report if procedure performed.
43888	Gastric restrictive procedure, open; removal and replacement of subcutaneous port component only	Prior Authorization Required	Obesity	Submit office evaluation including height and weight, treatment plan, proposed procedure, operative report if procedure performed.
43999	Unlisted procedure, stomach	Medical necessity review will be performed upon claims submission with supporting documentation.	Medical Necessity	Review required at claims submission; submit description of procedure with supporting documentation (including operative report if surgical) only for the date of service performed.
44135	Intestinal allotransplantation; from cadaver donor	Prior Authorization Required	Medical Necessity	Submit Transplant evaluation and facility acceptance letter
44136	Intestinal allotransplantation; from living donor	Prior Authorization Required	Medical Necessity	Submit Transplant evaluation and facility acceptance letter
44238	Unlisted laparoscopy procedure, intestine (except rectum)	Medical necessity review will be performed upon claims submission with supporting documentation.	Medical Necessity	Review required at claims submission; submit description of procedure with supporting documentation (including operative report if surgical) only for the date of service performed.

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44799	Unlisted procedure, intestine	Medical necessity review will be performed upon claims submission with supporting documentation.	Medical Necessity	Review required at claims submission; submit description of procedure with supporting documentation (including operative report if surgical) only for the date of service performed.
44899	Unlisted procedure, Meckel's diverticulum and the mesentery	Medical necessity review will be performed upon claims submission with supporting documentation.	Medical Necessity	Review required at claims submission; submit description of procedure with supporting documentation (including operative report if surgical) only for the date of service performed.
44979	Unlisted laparoscopy procedure, appendix	Medical necessity review will be performed upon claims submission with supporting documentation.	Medical Necessity	Review required at claims submission; submit description of procedure with supporting documentation (including operative report if surgical) only for the date of service performed.
45399	Unlisted procedure, colon	Medical necessity review will be performed upon claims submission with supporting documentation.	Medical Necessity	Review required at claims submission; submit description of procedure with supporting documentation (including operative report if surgical) only for the date of service performed.
45499	Unlisted laparoscopy procedure, rectum	Medical necessity review will be performed upon claims submission with supporting documentation.	Medical Necessity	Review required at claims submission; submit description of procedure with supporting documentation (including operative report if surgical) only for the date of service performed.
45999	Unlisted procedure, rectum	Medical necessity review will be performed upon claims submission with supporting documentation.	Medical Necessity	Review required at claims submission; submit description of procedure with supporting documentation (including operative report if surgical) only for the date of service performed.
46505	Chemodenervation of internal anal sphincter	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.

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46999	Unlisted procedure, anus	Medical necessity review will be performed upon claims submission with supporting documentation.	Medical Necessity	Review required at claims submission; submit description of procedure with supporting documentation (including operative report if surgical) only for the date of service performed.
47135	Liver allotransplantation; orthoptic; partial or whole, from cadaver or	Prior Authorization Required	Medical Necessity	Submit Transplant evaluation and facility acceptance letter
47379	Unlisted laparoscopic procedure, liver	Medical necessity review will be performed upon claims submission with supporting documentation.	Medical Necessity	Review required at claims submission; submit description of procedure with supporting documentation (including operative report if surgical) only for the date of service performed.
47382	Ablation, 1 or more liver tumor(s), percutaneous, radiofrequency	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity and procedure report.
47399	Unlisted procedure, liver	Medical necessity review will be performed upon claims submission with supporting documentation.	Medical Necessity	Review required at claims submission; submit description of procedure with supporting documentation (including operative report if surgical) only for the date of service performed.
47579	Unlisted laparoscopy procedure, biliary tract	Medical necessity review will be performed upon claims submission with supporting documentation.	Medical Necessity	Review required at claims submission; submit description of procedure with supporting documentation (including operative report if surgical) only for the date of service performed.
47999	Unlisted procedure, biliary tract	Medical necessity review will be performed upon claims submission with supporting documentation.	Medical Necessity	Review required at claims submission; submit description of procedure with supporting documentation (including operative report if surgical) only for the date of service performed.
48160	Pancreatectomy, total or subtotal, with autologous transplantation of pancreas or pancreatic islet cells	Prior Authorization Required	Medical Necessity	Submit Transplant evaluation and facility acceptance letter

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48554	Transplantation of pancreatic allograft	Prior Authorization Required	Medical Necessity	Submit Transplant evaluation and facility acceptance letter
48999	Unlisted procedure, pancreas	Medical necessity review will be performed upon claims submission with supporting documentation.	Medical Necessity	Review required at claims submission; submit description of procedure with supporting documentation (including operative report if surgical) only for the date of service performed.
49329	Unlisted laparoscopy procedure, abdomen, peritoneum and omentum	Medical necessity review will be performed upon claims submission with supporting documentation.	Medical Necessity	Review required at claims submission; submit description of procedure with supporting documentation (including operative report if surgical) only for the date of service performed.
49659	Unlisted laparoscopy procedure, hernioplasty, herniorrhaphy, herniotomy	Medical necessity review will be performed upon claims submission with supporting documentation.	Medical Necessity	Review required at claims submission; submit description of procedure with supporting documentation (including operative report if surgical) only for the date of service performed.
49999	Unlisted procedure, abdomen, peritoneum and omentum	Medical necessity review will be performed upon claims submission with supporting documentation.	Medical Necessity	Review required at claims submission; submit description of procedure with supporting documentation (including operative report if surgical) only for the date of service performed.
50250	Ablation, open, 1 or more renal mass lesion(s), cryosurgical, including intraoperative ultrasound guidance and monitoring, if performed	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, operative report.
50360	Renal allotransplantation; implantation of graft; without recipient	Prior Authorization Required	Medical Necessity	Submit Transplant evaluation and facility acceptance letter
50365	Renal allotransplantation, implantation of graft; with recipient nephrectomy	Prior Authorization Required	Medical Necessity	Submit Transplant evaluation and facility acceptance letter
50542	Laparoscopy, surgical; ablation of renal mass lesion(s), including intraoperative ultrasound guidance and monitoring, when performed	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, operative report.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
50549	Unlisted laparoscopy procedure, renal	Medical necessity review will be performed upon claims submission with supporting documentation.	Medical Necessity	Review required at claims submission; submit description of procedure with supporting documentation (including operative report if surgical) only for the date of service performed.
50592	Ablation, one or more renal tumor(s), percutaneous, unilateral, radiofrequency	Prior Authorization Required	Medical Necessity	Recent History and Physical, plan of care, and documentation of medical necessity
50593	Ablation, renal tumor(s), unilateral, percutaneous, cryotherapy	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, operative report.
50949	Unlisted laparoscopy procedure, ureter	Medical necessity review will be performed upon claims submission with supporting documentation.	Medical Necessity	Review required at claims submission; submit description of procedure with supporting documentation (including operative report if surgical) only for the date of service performed.
51721	Insertion of transurethral ablation transducer for delivery of thermal ultrasound for prostate tissue ablation, including suprapubic tube placement during the same session and placement of an endorectal cooling device, when performed	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
51999	Unlisted laparoscopy procedure bladder	Medical necessity review will be performed upon claims submission with supporting documentation.	Medical Necessity	Review required at claims submission; submit description of procedure with supporting documentation (including operative report if surgical) only for the date of service performed.
52287	Cystourethroscopy, with injection(s) for chemodenervation of the bladder	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
53430	Urethroplasty, reconstruction of female urethra	Prior Authorization Required	Medical Necessity	Beginning 1/1/22 will only require review for WA members when submitted for gender transition/affirmation surgery. Submit history and physical, documentation of medical necessity and procedure report.
53854	Transurethral destruction of prostate tissue; by radiofrequency generated water vapor thermotherapy	Prior Authorization Required	Investigative	Submit history and physical, documentation of medical necessity and procedure report.
53865	Cystourethroscopy with insertion of temporary device for ischemic remodeling (ie, pressure necrosis) of bladder neck and prostate	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
53866	Catheterization with removal of temporary device for ischemic remodeling (ie, pressure necrosis) of bladder neck and prostate	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
53899	Unlisted urinary procedure	Medical necessity review will be performed upon claims submission with supporting documentation.	Medical Necessity	Review required at claims submission; submit description of procedure with supporting documentation (including operative report if surgical) only for the date of service performed.
54125	Amputation of penis; complete	Prior Authorization Required	Medical Necessity	Submit History and Physical, documentation of medical necessity, operative report
54231	Dynamic cavernosometry, including intracavernosal injection of vasoactive drugs (eg, papaverine, phentolamine)	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
54240	Penile plethysmography	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
54250	Nocturnal penile tumescence and/or rigidity test	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
54400	Insertion of penile prosthesis; non-inflatable (semi-rigid)	Non-covered Service	Benefit Exception	Submit records only when member's contract indicates coverage. Beginning 1/1/22 code will require review for WA members when submitted for gender transition/affirmation surgery unless otherwise specified by contract.
54401	Insertion of penile prosthesis; inflatable (self-contained)	Non-covered Service	Benefit Exception	Submit records only when member's contract indicates coverage. Beginning 1/1/22 code will require review for WA members when submitted with gender dysphoria diagnosis unless otherwise specified by contract.
54405	Insertion of multi-component, inflatable penile prosthesis, including placement of pump, cylinders, and reservoir	Non-covered Service	Benefit Exception	Submit records only when member's contract indicates coverage. Beginning 1/1/22 code will require review for WA members when submitted for gender transition/affirmation surgery unless otherwise specified by contract.
54406	Removal of all components of a multi-component, inflatable penile prosthesis without replacement of prosthesis	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
54408	Repair of component(s) of a multi-component, inflatable penile prosthesis	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
54410	Removal and replacement of all component(s) of a multi-component, inflatable penile prosthesis at the same operative session	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
54411	Removal and replacement of all components of a multi-component inflatable penile prosthesis through an infected field at the same operative session, including irrigation and debridement of infected tissue	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
54415	Removal of non-inflatable (semi-rigid) or inflatable (self-contained) penile prosthesis, without replacement of prosthesis	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
54416	Removal and replacement of non-inflatable (semi-rigid) or inflatable (self-contained) penile prosthesis at the same operative session	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
54417	Removal and replacement of non-inflatable (semi-rigid) or inflatable (self-contained) penile prosthesis through an infected field at the same operative session, including irrigation and debridement of infected tissue	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
54520	Orchiectomy, simple (including subcapsular), with or without testicular prosthesis, scrotal or inguinal approach	Prior Authorization Required	Medical Necessity	Beginning 1/1/22 will only require review for WA members when submitted for gender transition/affirmation surgery. Submit history and physical, documentation of medical necessity and procedure report.
54660	Insertion of testicular prosthesis (separate procedure)	Prior Authorization Required	Medical Necessity	Submit History and Physical, documentation of medical necessity, operative report
54699	Unlisted laparoscopy procedure, testis	Medical necessity review will be performed upon claims submission with supporting documentation.	Medical Necessity	Review required at claims submission; submit description of procedure with supporting documentation (including operative report if surgical) only for the date of service performed.
55180	Scrotoplasty; complicated	Prior Authorization Required	Medical Necessity	Submit History and Physical, documentation of medical necessity, operative report

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
55400	Vasovasostomy, vasovasorrhaphy	Prior Authorization Required	Medical Necessity	Submit History and Physical, documentation of medical necessity, operative report
55559	Unlisted laparoscopy procedure, spermatic cord	Medical necessity review will be performed upon claims submission with supporting documentation.	Medical Necessity	Review required at claims submission; submit description of procedure with supporting documentation (including operative report if surgical) only for the date of service performed.
55860	Exposure of prostate, any approach, for insertion of radioactive substance	Prior Authorization Required	Radiation Oncology	No review for non-cancer diagnoses. FOR CANCER DIAGNOSES ONLY: Submit online review with Carelon at www.providerportal.com. For prior authorization include history and physical, results of previous diagnostics procedure report.
55862	Exposure of prostate, any approach, for insertion of radioactive substance; with lymph node biopsy(s) (limited pelvic lymphadenectomy)	Prior Authorization Required	Radiation Oncology	No review for non-cancer diagnoses. FOR CANCER DIAGNOSES ONLY: Submit online review with Carelon at www.providerportal.com. For prior authorization include history and physical, results of previous diagnostics procedure report.
55865	Exposure of prostate, any approach, for insertion of radioactive substance; with bilateral pelvic lymphadenectomy, including external iliac, hypogastric and obturator nodes	Prior Authorization Required	Radiation Oncology	No review for non-cancer diagnoses. FOR CANCER DIAGNOSES ONLY: Submit online review with Carelon at www.providerportal.com. For prior authorization include history and physical, results of previous diagnostics procedure report.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
55874	Transperineal placement of biodegradable material, peri-prostatic, single or multiple injection(s), including image guidance, when performed	Prior Authorization Required	Radiation Oncology	No review for non-cancer diagnoses. FOR CANCER DIAGNOSES ONLY: Submit online review with Carelon at www.providerportal.com. For prior authorization include history and physical, results of previous diagnostics procedure report.
55875	Transperineal placement of needles or catheters into prostate for interstitial radioelement application, with or without cystoscopy	Prior Authorization Required	Radiation Oncology	No review for non-cancer diagnoses. FOR CANCER DIAGNOSES ONLY: Submit online review with Carelon at www.providerportal.com. For prior authorization include history and physical, results of previous diagnostics procedure report.
55880	Ablation of malignant prostate tissue, transrectal, with high intensity-focused ultrasound (HIFU), including ultrasound guidance	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
55881	Ablation of prostate tissue, transurethral, using thermal ultrasound, including magnetic resonance imaging guidance for, and monitoring of, tissue ablation;	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
55882	Ablation of prostate tissue, transurethral, using thermal ultrasound, including magnetic resonance imaging guidance for, and monitoring of, tissue ablation; with insertion of transurethral ultrasound transducer for delivery of thermal ultrasound, including suprapubic tube placement and placement of an endorectal cooling device, when performed	Possible Denial; Medical Records Optional	Investigative	Documentation optional.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
55899	Unlisted procedure, male genital system	Medical necessity review will be performed upon claims submission with supporting documentation.	Medical Necessity	Review required at claims submission; submit description of procedure with supporting documentation (including operative report if surgical) only for the date of service performed.
55920	Placement of needles or catheters into pelvic organs and/or genitalia (except prostate) for subsequent interstitial radioelement application	Prior Authorization Required	Radiation Oncology	No review for non-cancer diagnoses. FOR CANCER DIAGNOSES ONLY: Submit online review with Carelon at www.providerportal.com. For prior authorization include history and physical, results of previous diagnostics procedure report.
55970	Intersex surgery; male to female	Prior Authorization Required	Medical Necessity	Submit History and Physical, documentation of medical necessity, operative report
55980	Intersex surgery; female to male	Prior Authorization Required	Medical Necessity	Submit History and Physical, documentation of medical necessity, operative report
56620	Vulvectomy simple; partial	Pre-Service Review Required	Cosmetic - Reconstructive	Submit history and physical, documentation of medical necessity and procedure report.
56625	Vulvectomy simple; complete	Prior Authorization Required	Medical Necessity	Submit History and Physical, documentation of medical necessity, operative report
56800	Plastic repair of introitus	Pre-Service Review Required	Medical Necessity	Submit History and Physical, documentation of medical necessity, operative report
56805	Clitoroplasty for intersex state	Prior Authorization Required	Medical Necessity	Submit History and Physical, documentation of medical necessity, operative report
57110	Vaginectomy, complete removal of vaginal wall;	Prior Authorization Required	Medical Necessity	Submit History and Physical, documentation of medical necessity, operative report

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
57155	Insertion of uterine tandems and/or vaginal ovoid for clinical brachytherapy	Prior Authorization Required	Radiation Oncology	No review for non-cancer diagnoses. FOR CANCER DIAGNOSES ONLY: Submit online review with Carelon at www.providerportal.com. For prior authorization include history and physical, results of previous diagnostics procedure report.
57156	Insertion of a vaginal radiation afterloading apparatus for clinical brachytherapy	Prior Authorization Required	Radiation Oncology	No review for non-cancer diagnoses. FOR CANCER DIAGNOSES ONLY: Submit online review with Carelon at www.providerportal.com. For prior authorization include history and physical, results of previous diagnostics procedure report.
57291	Construction of artificial vagina; without graft	Prior Authorization Required	Medical Necessity	Submit History and Physical, documentation of medical necessity, operative report
57292	Construction of artificial vagina; with graft	Prior Authorization Required	Medical Necessity	Submit History and Physical, documentation of medical necessity, operative report
57295	Revision (including removal) of prosthetic vaginal graft; vaginal approach	Pre-Service Review Required	Medical Necessity	Submit History and Physical, documentation of medical necessity, operative report
57296	Revision (including removal) of prosthetic vaginal graft; open abdominal approach	Pre-Service Review Required	Medical Necessity	Submit History and Physical, documentation of medical necessity, operative report
57335	Vaginoplasty for intersex state	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity and procedure report.
57426	Revision (including removal) of prosthetic vaginal graft, laparoscopic approach	Pre-Service Review Required	Medical Necessity	Submit History and Physical, documentation of medical necessity, operative report

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
58150	Total abdominal hysterectomy (corpus and cervix), with or without removal of tube(s), with or without removal of ovary(s);	Prior Authorization Required	Medical Necessity	Submit History and Physical, documentation of medical necessity, operative report. No review required for gynecologic malignant conditions.
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 Required	Medical Necessity	Submit History and Physical, documentation of medical necessity, operative report. No review required for gynecologic malignant conditions.
58180	Supracervical abdominal hysterectomy (subtotal hysterectomy), with or without removal of tube(s), with or without removal of ovary(s)	Prior Authorization Required	Medical Necessity	Submit History and Physical, documentation of medical necessity, operative report. No review required for gynecologic malignant conditions.
58260	Vaginal hysterectomy, for uterus 250 g or less;	Prior Authorization Required	Medical necessity including site of service	Submit History and Physical, documentation of medical necessity, operative report. No review required for gynecologic malignant conditions.
58262	Vaginal hysterectomy, for uterus 250 g or less; with removal of tube(s), and/or ovary(s)	Prior Authorization Required	Medical necessity including site of service	Submit History and Physical, documentation of medical necessity, operative report. No review required for gynecologic malignant conditions.
58263	Vaginal hysterectomy, for uterus 250 g or less; with removal of tube(s), and/or ovary(s), with repair of enterocele	Prior Authorization Required	Medical necessity including site of service	Submit History and Physical, documentation of medical necessity, operative report. No review required for gynecologic malignant conditions.
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 Required	Medical necessity including site of service	Submit History and Physical, documentation of medical necessity, operative report. No review required for gynecologic malignant conditions.
58270	Vaginal hysterectomy, for uterus 250 g or less; with repair of enterocele	Prior Authorization Required	Medical necessity including site of service	Submit History and Physical, documentation of medical necessity, operative report. No review required for gynecologic malignant conditions.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
58275	Vaginal hysterectomy, with total or partial vaginectomy;	Prior Authorization Required	Medical necessity including site of service	Submit History and Physical, documentation of medical necessity, operative report. No review required for gynecologic malignant conditions.
58280	Vaginal hysterectomy, with total or partial vaginectomy; with repair of enterocele	Prior Authorization Required	Medical necessity including site of service	Submit History and Physical, documentation of medical necessity, operative report. No review required for gynecologic malignant conditions.
58290	Vaginal hysterectomy, for uterus greater than 250 grams;	Prior Authorization Required	Medical necessity including site of service	Submit History and Physical, documentation of medical necessity, operative report. No review required for gynecologic malignant conditions.
58291	Vaginal hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)	Prior Authorization Required	Medical necessity including site of service	Submit History and Physical, documentation of medical necessity, operative report. No review required for gynecologic malignant conditions.
58292	Vaginal hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s), with repair of enterocele	Prior Authorization Required	Medical necessity including site of service	Submit History and Physical, documentation of medical necessity, operative report. No review required for gynecologic malignant conditions.
58294	Vaginal hysterectomy, for uterus greater than 250 g; with repair of enterocele	Prior Authorization Required	Medical necessity including site of service	Submit History and Physical, documentation of medical necessity, operative report. No review required for gynecologic malignant conditions.
58346	Insertion of Heyman capsules for clinical brachytherapy	Prior Authorization Required	Radiation Oncology	No review for non-cancer diagnoses. FOR CANCER DIAGNOSES ONLY: Submit online review with Carelon at www.providerportal.com. For prior authorization include history and physical, results of previous diagnostics procedure report.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
58541	Laparoscopy, surgical, supracervical hysterectomy, for uterus 250 g or less;	Prior Authorization Required	Medical Necessity	Submit History and Physical, documentation of medical necessity, operative report. No review required for gynecologic malignant conditions.
58542	Laparoscopy, surgical, supracervical hysterectomy, for uterus 250 g or less; with removal of tube(s) and/or ovary(s)	Prior Authorization Required	Medical Necessity	Submit History and Physical, documentation of medical necessity, operative report. No review required for gynecologic malignant conditions.
58543	Laparoscopy, surgical, supracervical hysterectomy, for uterus greater than 250 g;	Prior Authorization Required	Medical Necessity	Submit History and Physical, documentation of medical necessity, operative report. No review required for gynecologic malignant conditions.
58544	Laparoscopy, surgical, supracervical hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)	Prior Authorization Required	Medical Necessity	Submit History and Physical, documentation of medical necessity, operative report. No review required for gynecologic malignant conditions.
58550	Laparoscopy, surgical, with vaginal hysterectomy, for uterus 250 g or less;	Prior Authorization Required	Medical necessity including site of service	Submit History and Physical, documentation of medical necessity, operative report. No review required for gynecologic malignant conditions.
58552	Laparoscopy, surgical, with vaginal hysterectomy, for uterus 250 g or less; with removal of tube(s) and/or ovary(s)	Prior Authorization Required	Medical necessity including site of service	Submit History and Physical, documentation of medical necessity, operative report. No review required for gynecologic malignant conditions.
58553	Laparoscopy, surgical, with vaginal hysterectomy, for uterus greater than 250 grams	Prior Authorization Required	Medical necessity including site of service	Submit History and Physical, documentation of medical necessity, operative report. No review required for gynecologic malignant conditions.
58554	Laparoscopy, surgical, with vaginal hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)	Prior Authorization Required	Medical necessity including site of service	Submit History and Physical, documentation of medical necessity, operative report. No review required for gynecologic malignant conditions.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
58570	Laparoscopy, surgical, with total hysterectomy, for uterus 250 g or less;	Prior Authorization Required	Medical Necessity	Submit History and Physical, documentation of medical necessity, operative report. No review required for gynecologic malignant conditions.
58571	Laparoscopy, surgical, with total hysterectomy, for uterus 250 g or less; with removal of tube(s) and/or ovary(s)	Prior Authorization Required	Medical Necessity	Submit History and Physical, documentation of medical necessity, operative report. No review required for gynecologic malignant conditions.
58572	Laparoscopy, surgical, with total hysterectomy, for uterus greater than 250 g;	Prior Authorization Required	Medical Necessity	Submit History and Physical, documentation of medical necessity, operative report. No review required for gynecologic malignant conditions.
58573	Laparoscopy, surgical, with total hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)	Prior Authorization Required	Medical Necessity	Submit History and Physical, documentation of medical necessity, operative report. No review required for gynecologic malignant conditions.
58578	Unlisted laparoscopy procedure, uterus	Medical necessity review will be performed upon claims submission with supporting documentation.	Medical Necessity	Review required at claims submission; submit description of procedure with supporting documentation (including operative report if surgical) only for the date of service performed.
58579	Unlisted hysteroscopy procedure, uterus	Medical necessity review will be performed upon claims submission with supporting documentation.	Medical Necessity	Review required at claims submission; submit description of procedure with supporting documentation (including operative report if surgical) only for the date of service performed.
58672	Laparoscopy, surgical; with fimbrioplasty	Prior Authorization Required	Medical Necessity	Submit History and Physical, documentation of medical necessity, operative report
58673	Laparoscopy, surgical; with salpingostomy (salpingoneostomy)	Prior Authorization Required	Medical Necessity	Submit History and Physical, documentation of medical necessity, operative report

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
58679	Unlisted laparoscopy procedure, oviduct, ovary	Medical necessity review will be performed upon claims submission with supporting documentation.	Medical Necessity	Review required at claims submission; submit description of procedure with supporting documentation (including operative report if surgical) only for the date of service performed.
58750	Tubotubal anastomosis	Prior Authorization Required	Medical Necessity	Submit History and Physical, documentation of medical necessity, operative report
58760	Fimbrioplasty	Prior Authorization Required	Medical Necessity	Submit History and Physical, documentation of medical necessity, operative report
58999	Unlisted procedure, female genital system (nonobstetrical)	Medical necessity review will be performed upon claims submission with supporting documentation.	Medical Necessity	Review required at claims submission; submit description of procedure with supporting documentation (including operative report if surgical) only for the date of service performed.
59897	Unlisted fetal invasive procedure, including ultrasound guidance, when performed	Medical necessity review will be performed upon claims submission with supporting documentation.	Medical Necessity	Review required at claims submission; submit description of procedure with supporting documentation (including operative report if surgical) only for the date of service performed.
59898	Unlisted laparoscopy procedure, maternity care and delivery	Medical necessity review will be performed upon claims submission with supporting documentation.	Medical Necessity	Review required at claims submission; submit description of procedure with supporting documentation (including operative report if surgical) only for the date of service performed.
60659	Unlisted laparoscopy procedure, endocrine system	Medical necessity review will be performed upon claims submission with supporting documentation.	Medical Necessity	Review required at claims submission; submit description of procedure with supporting documentation (including operative report if surgical) only for the date of service performed.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
60660	Ablation of 1 or more thyroid nodule(s), one lobe or the isthmus, percutaneous, including imaging guidance, radiofrequency	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
60661	Ablation of 1 or more thyroid nodule(s), additional lobe, percutaneous, including imaging guidance, radiofrequency (List separately in addition to code for primary procedure)	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
60699	Unlisted procedure, endocrine system	Medical necessity review will be performed upon claims submission with supporting documentation.	Medical Necessity	Review required at claims submission; submit description of procedure with supporting documentation (including operative report if surgical) only for the date of service performed.
61715	Magnetic resonance image guided high intensity focused ultrasound (MRgFUS), stereotactic ablation of target, intracranial, including stereotactic navigation and frame placement, when performed	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
61736	Laser interstitial thermal therapy (LITT) of lesion, intracranial, including burr hole(s), with magnetic resonance imaging guidance, when performed; single trajectory for 1 simple lesion	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
61737	Laser interstitial thermal therapy (LITT) of lesion, intracranial, including burr hole(s), with magnetic resonance imaging guidance, when performed; multiple trajectories for multiple or complex lesion(s)	Possible Denial; Medical Records Optional	Investigative	Documentation optional.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
61796	Stereotactic radiosurgery (particle beam, gamma ray, or linear accelerator); 1 simple cranial lesion	Prior Authorization Required	Radiation Oncology	No review for non-cancer diagnoses. FOR CANCER DIAGNOSES ONLY: Submit online review with Carelon at www.providerportal.com. For prior authorization include history and physical, results of previous diagnostics procedure report.
61800	Application of stereotactic headframe for stereotactic radiosurgery (List separately in addition to code for primary procedure)	Prior Authorization Required	Radiation Oncology	No review for non-cancer diagnoses. FOR CANCER DIAGNOSES ONLY: Submit online review with Carelon at www.providerportal.com. For prior authorization include history and physical, results of previous diagnostics procedure report.
61850	Twist drill or burr hole(s) for implantation of neurostimulator electrodes, cortical	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity and procedure report.
61860	Craniectomy or craniotomy for implantation of neurostimulator electrodes, cerebral, cortical	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity and procedure report.
61863	Twist drill, burr hole, craniotomy, or craniectomy with stereotactic implantation of neurostimulator electrode array in subcortical site without use of intraoperative microelectrode recording; first array	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity and procedure report.
61864	Twist drill, burr hole, craniotomy, or craniectomy with stereotactic implantation of neurostimulator electrode array in subcortical site without use of intraoperative microelectrode recording; each additional array	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity and procedure report.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
61867	Twist drill, burr hole, craniotomy, or craniectomy with stereotactic implantation of neurostimulator electrode array in subcortical site with use of intraoperative microelectrode recording; first array	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity and procedure report.
61868	Twist drill, burr hole, craniotomy, or craniectomy with stereotactic implantation of neurostimulator electrode array in subcortical site with use of intraoperative microelectrode recording; each additional array	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity and procedure report.
61885	Insertion or replacement of cranial neurostimulator pulse generator or receiver, direct or inductive coupling; with connection to a single electrode array	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity and procedure report.
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 Required	Medical Necessity	Submit history and physical, documentation of medical necessity and procedure report.
61889	Insertion of skull-mounted cranial neurostimulator pulse generator or receiver, including craniectomy or craniotomy, when performed, with direct or inductive coupling with connection	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
61891	Revision or replacement of skull-mounted cranial neurostimulator pulse generator or receiver with connection to depth and/or cortical strip electrode array(s)	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.

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62281	Injection/infusion of neurolytic substance (eg, alcohol, phenol, iced saline solutions), with or without other therapeutic substance; epidural, cervical or thoracic	Prior Authorization Required	Investigative	Submit history and Physical, operative report, documentation of conservative measures.
62287	Decompression procedure, percutaneous, of nucleus pulposus of intervertebral disc, any method, single or multiple levels, lumbar	Pre-Service Review Required	Investigative	Submit history and physical, documentation of medical necessity and procedure report.
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	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
63001	Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina, without facetectomy, foraminotomy or discectomy (eg, spinal stenosis), 1 or 2 vertebral segments; cervical	Prior Authorization Required	Medical necessity including site of service	Submit recent history and physical, plan of care, and documentation of medical necessity including for site of service.
63005	Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina, without facetectomy, foraminotomy or discectomy, 1 or 2 vertebral segments; lumbar, except for spondylolisthesis	Prior Authorization Required	Medical necessity including site of service	Submit Site of Service, History and Physical, prior back surgeries, including minimally invasive, conservative management, MRI/CT, operative report. No review needed for members under age 18.
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 Required	Medical necessity including site of service	Submit Site of Service, History and Physical, prior back surgeries, including minimally invasive, conservative management, MRI/CT, operative report. No review needed for members age 18 and under.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
63015	Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina, without facetectomy, foraminotomy or discectomy (eg, spinal stenosis), more than 2 vertebral segments; cervical	Prior Authorization Required	Medical necessity including site of service	Submit recent history and physical, plan of care, and documentation of medical necessity including for site of service.
63017	Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina, without facetectomy, foraminotomy or discectomy (eg, spinal stenosis), more than 2 vertebral segments; lumbar	Prior Authorization Required	Medical necessity including site of service	Submit Site of Service, History and Physical, prior back surgeries, including minimally invasive, conservative management, MRI/CT, operative report. No review needed for members under age 18.
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 Required	Medical necessity including site of service	Submit recent history and physical, plan of care, and documentation of medical necessity including for site of service. No review needed for members under age 18.
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 Required	Medical necessity including site of service	Submit Site of Service, History and Physical, prior back surgeries, including minimally invasive, conservative management, MRI/CT, operative report. No review needed for members under age 18.
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	Prior Authorization Required	Medical necessity including site of service	Submit Site of Service, History and Physical, prior back surgeries, including minimally invasive, conservative management, MRI/CT, operative report. No review needed for members under age 18.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
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 Required	Medical necessity including site of service	Submit recent history and physical, plan of care, and documentation of medical necessity including for site of service.
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 Required	Medical necessity including site of service	Submit Site of Service, History and Physical, prior back surgeries, including minimally invasive, conservative management, MRI/CT, operative report. No review needed for members under age 18.
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	Prior Authorization Required	Medical necessity including site of service	Submit Site of Service, History and Physical, prior back surgeries, including minimally invasive, conservative management, MRI/CT, operative report. No review needed for members under age 18.
63045	Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [eg, spinal or lateral recess stenosis]), single vertebral segment; cervical	Prior Authorization Required	Medical necessity including site of service	Submit recent history and physical, plan of care, and documentation of medical necessity including for site of service. No review needed for members under age 18.
63047	Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [eg, spinal or lateral recess stenosis]), single vertebral segment; lumbar	Prior Authorization Required	Medical necessity including site of service	Submit Site of Service, History and Physical, prior back surgeries, including minimally invasive, conservative management, MRI/CT, operative report. No review needed for members age 18 and under.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
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 segment, cervical, thoracic, or lumbar	Prior Authorization Required	Medical necessity including site of service	Submit Site of Service, History and Physical, prior back surgeries, including minimally invasive, conservative management, MRI/CT, operative report. No review needed for members under age 18.
63050	Laminoplasty, cervical, with decompression of the spinal cord, 2 or more vertebral segments;	Prior Authorization Required	Medical necessity including site of service	Submit recent history and physical, plan of care, and documentation of medical necessity including for site of service.
63051	Laminoplasty, cervical, with decompression of the spinal cord, 2 or more vertebral segments; with reconstruction of the posterior bony elements (including the application of bridging bone graft and non-segmental fixation devices [eg, wire, suture, mini-plates], when performed)	Prior Authorization Required	Medical necessity including site of service	Submit recent history and physical, plan of care, and documentation of medical necessity including for site of service.
63052	Laminectomy, facetectomy, or foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s] [eg, spinal or lateral recess stenosis]), during posterior interbody arthrodesis, lumbar; single vertebral segment (List separately in addition to code for primary procedure)	Prior Authorization Required	Medical necessity including site of service	Submit recent history and physical, plan of care, and documentation of medical necessity including for site of service.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
63053	Laminectomy, facetectomy, or foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s] [eg, spinal or lateral recess stenosis]), during posterior interbody arthrodesis, lumbar; each additional segment (List separately in addition to code for primary procedure)T	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity and procedure report.
63056	Transpedicular approach with decompression of spinal cord, equina and/or nerve root(s) (eg, herniated intervertebral disc), single segment; lumbar (including transfacet, or lateral extraforaminal approach) (eg, far lateral herniated intervertebral disc)	Prior Authorization Required	Medical necessity including site of service	Submit Site of Service, History and Physical, prior back surgeries, including minimally invasive, conservative management, MRI/CT, operative report. No review needed for members under age 18.
63057	Transpedicular approach with decompression of spinal cord, equina and/or nerve root(s) (eg, herniated intervertebral disc), single segment; each additional segment, thoracic or lumbar (List separately in addition to code for primary procedure)	Prior Authorization Required	Medical necessity including site of service	Submit Site of Service, History and Physical, prior back surgeries, including minimally invasive, conservative management, MRI/CT, operative report. No review needed for members under age 18.
63075	Discectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophytectomy; cervical, single interspace	Prior Authorization Required	Medical necessity including site of service	Submit recent history and physical, plan of care, and documentation of medical necessity including for site of service.
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 Required	Medical necessity including site of service	Submit recent history and physical, plan of care, and documentation of medical necessity including for site of service.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
63185	Laminectomy with rhizotomy; 1 or 2 segments	Prior Authorization Required	Medical necessity including site of service	Submit Site of Service, History and Physical, prior back surgeries, including minimally invasive, conservative management, MRI/CT, operative report. No review needed for members under age 18.
63190	Laminectomy with rhizotomy; more than 2 segments	Prior Authorization Required	Medical necessity including site of service	Submit Site of Service, History and Physical, prior back surgeries, including minimally invasive, conservative management, MRI/CT, operative report. No review needed for members under age 18.
63191	Laminectomy with section of spinal accessory nerve	Prior Authorization Required	Medical necessity including site of service	Submit Site of Service, History and Physical, prior back surgeries, including minimally invasive, conservative management, MRI/CT, operative report. No review needed for members under age 18.
63265	Laminectomy for excision or evacuation of intraspinal lesion other than neoplasm, extradural; cervical	Prior Authorization Required	Medical necessity including site of service	Submit recent history and physical, plan of care, and documentation of medical necessity including for site of service.
63267	Laminectomy for excision or evacuation of intraspinal lesion other than neoplasm, extradural; lumbar	Prior Authorization Required	Medical necessity including site of service	Submit Site of Service, History and Physical, prior back surgeries, including minimally invasive, conservative management, MRI/CT, operative report. No review needed for members under age 18.
63272	Laminectomy for excision of intraspinal lesion other than neoplasm, intradural; lumbar	Prior Authorization Required	Medical necessity including site of service	Submit Site of Service, History and Physical, prior back surgeries, including minimally invasive, conservative management, MRI/CT, operative report. No review needed for members under age 18.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
63620	Stereotactic radiosurgery (particle beam, gamma ray, or linear accelerator); 1 spinal lesion	Prior Authorization Required	Radiation Oncology	No review for non-cancer diagnoses. FOR CANCER DIAGNOSES ONLY: Submit online review with Carelon at www.providerportal.com. For prior authorization include history and physical, results of previous diagnostics procedure report.
63621	Stereotactic radiosurgery (particle beam, gamma ray, or linear accelerator); each additional spinal lesion (List separately in addition to code for primary procedure)	Prior Authorization Required	Radiation Oncology	No review for non-cancer diagnoses. FOR CANCER DIAGNOSES ONLY: Submit online review with Carelon at www.providerportal.com. For prior authorization include history and physical, results of previous diagnostics procedure report.
63650	Percutaneous implantation of neurostimulator electrode array, epidural	Prior Authorization Required	Medical necessity including site of service	Submit recent history and physical, plan of care, and documentation of medical necessity including for site of service.
63655	Laminectomy for implantation of neurostimulator electrodes, plate/paddle, epidural	Prior Authorization Required	Medical necessity including site of service	Submit recent history and physical, plan of care, and documentation of medical necessity including for site of service.
63661	Removal of spinal neurostimulator electrode percutaneous array(s), including fluoroscopy, when performed	Prior Authorization Required	Medical necessity including site of service	Submit recent history and physical, plan of care, and documentation of medical necessity including for site of service.
63662	Removal of spinal neurostimulator electrode plate/paddle(s) placed via laminotomy or laminectomy, including fluoroscopy, when performed	Prior Authorization Required	Medical necessity including site of service	Submit recent history and physical, plan of care, and documentation of medical necessity including for site of service.
63663	Revision including replacement, when performed, of spinal neurostimulator electrode percutaneous array(s), including fluoroscopy, when performed	Prior Authorization Required	Medical necessity including site of service	Submit recent history and physical, plan of care, and documentation of medical necessity including for site of service.

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63664	Revision including replacement, when performed, of spinal neurostimulator electrode plate/paddle(s) placed via laminotomy or laminectomy, including fluoroscopy, when performed	Prior Authorization Required	Medical necessity including site of service	Submit recent history and physical, plan of care, and documentation of medical necessity including for site of service.
63685	Insertion or replacement of spinal neurostimulator pulse generator or receiver, requiring pocket creation and connection between electrode array and pulse generator receiver	Prior Authorization Required	Medical necessity including site of service	Submit recent history and physical, plan of care, and documentation of medical necessity including for site of service.
63688	Revision or removal of implanted spinal neurostimulator pulse generator or receiver, with detachable connection to electrode array	Prior Authorization Required	Medical necessity including site of service	Submit recent history and physical, plan of care, and documentation of medical necessity including for site of service.
64553	Percutaneous implantation of neurostimulator electrodes; cranial nerve	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity and procedure report.
64555	Percutaneous implantation of neurostimulator electrodes; peripheral nerve (excludes sacral nerve)	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
64561	Percutaneous implantation of neurostimulator electrodes sacral nerve (transforaminal placement)	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity and procedure report.
64568	Incision for implantation of cranial nerve (eg, vagus nerve) neurostimulator electrode array and pulse generator	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, operative report.
64569	Revision or replacement of cranial nerve (eg, vagus nerve) neurostimulator electrode array, including connection to existing pulse generator	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, operative report.
64575	Incision for implantation of neurostimulator electrode array; peripheral nerve (excludes sacral nerve)	Possible Denial; Medical Records Optional	Investigative	Documentation optional.

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64581	Incision of implantation of neurostimulator electrodes sacral nerve (transforaminal placement)	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity and procedure report.
64582	Open implantation of hypoglossal nerve neurostimulator array, pulse generator, and distal respiratory sensor electrode or electrode array	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity and procedure report.
64583	Revision or replacement of hypoglossal nerve neurostimulator array and distal respiratory sensor electrode or electrode array, including connection to existing pulse generator	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity and procedure report.
64584	Removal of hypoglossal nerve neurostimulator array, pulse generator, and distal respiratory sensor electrode or electrode array	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity and procedure report.
64585	Revision or removal of peripheral neurostimulator electrode array	Pre-Service Review Required	Medical Necessity	Submit history and physical, documentation of medical necessity and procedure report.
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	Pre-Service Review Required	Medical Necessity	Submit history and physical, documentation of medical necessity and procedure report.
64595	Revision or removal of peripheral, sacral, or gastric neurostimulator pulse generator or receiver, with detachable connection to electrode array	Pre-Service Review Required	Medical Necessity	Submit history and physical, documentation of medical necessity and procedure report.
64596	Insertion or replacement of percutaneous electrode array, peripheral nerve, with integrated neurostimulator, including imaging guidance, when performed; initial electrode array	Pre-Service Review Required	Medical Necessity	Submit history and physical, documentation of medical necessity.

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64597	Insertion or replacement of percutaneous electrode array, peripheral nerve, with integrated neurostimulator, including imaging guidance, when performed; each additional electrode array	Pre-Service Review Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
64600	Destruction by neurolytic agent, trigeminal nerve; supraorbital, infraorbital, mental, or inferior alveolar branch	Prior Authorization Required	Investigative	Submit history and physical, documentation of medical necessity and procedure report.
64611	Chemodenervation of parotid and submandibular salivary glands, bilateral	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
64612	Chemodenervation of muscle(s); muscle(s) innervated by facial nerve, unilateral (eg, for blepharospasm, hemifacial spasm)	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
64615	Chemodenervation of muscle(s); muscle(s) innervated by facial, trigeminal, cervical spinal and accessory nerves, bilateral (eg, for chronic migraine)	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
64616	Chemodenervation of muscle(s); neck muscle(s), excluding muscles of the larynx, unilateral (eg, for cervical dystonia, spasmodic torticollis)	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
64617	Chemodenervation of muscle(s); larynx, unilateral, percutaneous (eg, for spasmodic dysphonia), includes guidance by needle electromyography, when performed	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
64620	Destruction by neurolytic agent, intercostal nerve	Possible Denial; Medical Records Optional	Investigative	Documentation optional.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
64624	Destruction by neurolytic agent, genicular nerve branches including imaging guidance, when performed	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
64625	Radiofrequency ablation, nerves innervating the sacroiliac joint, with image guidance (ie, fluoroscopy or computed tomography)	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
64628	Thermal destruction of intraosseous basivertebral nerve, including all imaging guidance; first 2 vertebral bodies, lumbar or sacral	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
64629	Thermal destruction of intraosseous basivertebral nerve, including all imaging guidance; each additional vertebral body, lumbar or sacral (List separately in addition to code for primary procedure)	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
64632	Destruction by neurolytic agent; plantar common digital nerve	Pre-Service Review Required	Investigative	Submit history and physical, documentation of medical necessity and procedure report.
64633	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); cervical or thoracic, single facet joint	Prior Authorization Required	Medical Necessity	History and Physical, operative report, documentation of conservative measures
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 Required	Medical Necessity	History and Physical, operative report, documentation of conservative measures
64635	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); lumbar or sacral, single facet joint	Prior Authorization Required	Medical Necessity	History and Physical, operative report, documentation of conservative measures

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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 Required	Medical Necessity	History and Physical, operative report, documentation of conservative measures
64640	Destruction by neurolytic agent; other peripheral nerve or branch	Prior Authorization Required	Medical Necessity	History and Physical, operative report, documentation of conservative measures
64642	Chemodenervation of one extremity; 1-4 muscle(s)	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
64643	Chemodenervation of one extremity; each additional extremity, 1-4 muscle(s) (List separately in addition to code for primary procedure)	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
64644	Chemodenervation of one extremity; 5 or more muscles	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
64645	Chemodenervation of one extremity; each additional extremity, 5 or more muscles (List separately in addition to code for primary procedure)	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
64646	Chemodenervation of trunk muscle(s); 1-5 muscle(s)	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity. ###Botulinum toxin (botox), onabotulinumtoxinA and chemodenervation may be approved without review under the same UM when one already exists for either service. No review for Amazon.
64647	Chemodenervation of trunk muscle(s); 6 or more muscles	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
64650	Chemodenervation of eccrine glands; both axillae	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.

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64653	Chemodenervation of eccrine glands; other area(s) (eg, scalp, face, neck), per day	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
64721	Neuroplasty and/or transposition; median nerve at carpal tunnel	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity and procedure report.
64818	Sympathectomy, lumbar	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
64910	Nerve repair; with synthetic conduit or vein allograft (eg, nerve tube), each nerve	Prior Authorization Required	Investigative	Submit history and physical, documentation of medical necessity and procedure report.
64912	Nerve repair; with nerve allograft, each nerve, first strand (cable)	Prior Authorization Required	Investigative	Submit history and physical, documentation of medical necessity and procedure report.
64913	Nerve repair; with nerve allograft, each additional strand (List separately in addition to code for primary procedure)	Prior Authorization Required	Investigative	Submit history and physical, documentation of medical necessity and procedure report.
64999	Unlisted procedure, nervous system	Medical necessity review will be performed upon claims submission with supporting documentation.	Medical Necessity	Review required at claims submission; submit description of procedure with supporting documentation (including operative report if surgical) only for the date of service performed.
66999	Unlisted procedure of the eye	Medical necessity review will be performed upon claims submission with supporting documentation.	Medical Necessity	Review required at claims submission; submit description of procedure with supporting documentation (including operative report if surgical) only for the date of service performed.
67218	Destruction of localized lesion of retina (eg, macular edema, tumors), 1 or more sessions; radiation by implantation of source (includes removal of source)	Prior Authorization Required	Radiation Oncology	No review for non-cancer diagnoses. FOR CANCER DIAGNOSES ONLY: Submit online review with Carelon at www.providerportal.com. For prior authorization include history and physical, results of previous diagnostics procedure report.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
67299	Unlisted procedure, posterior segment	Medical necessity review will be performed upon claims submission with supporting documentation.	Medical Necessity	Review required at claims submission; submit description of procedure with supporting documentation (including operative report if surgical) only for the date of service performed.
67345	Chemodenervation of extraocular muscle	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
67399	Unlisted procedure, ocular muscle	Medical necessity review will be performed upon claims submission with supporting documentation.	Medical Necessity	Review required at claims submission; submit description of procedure with supporting documentation (including operative report if surgical) only for the date of service performed.
67599	Unlisted procedure, orbit	Medical necessity review will be performed upon claims submission with supporting documentation.	Medical Necessity	Review required at claims submission; submit description of procedure with supporting documentation (including operative report if surgical) only for the date of service performed.
67900	Repair of brow ptosis (supraciliary, mid-forehead or coronal approach)	Prior Authorization Required	Medical Necessity	Pre Operative Evaluation, History and Physical including functional impairment, and operative report including photos
67901	Repair of blepharoptosis; frontalis muscle technique with suture or other material (eg, banked fascia)	Prior Authorization Required	Medical Necessity	Pre Operative Evaluation, History and Physical including functional impairment, and operative report including photos
67902	Repair of blepharoptosis; frontalis muscle technique with autologous fascial sling (includes obtaining fascia)	Prior Authorization Required	Medical Necessity	Pre Operative Evaluation, History and Physical including functional impairment, and operative report including photos
67903	Repair of blepharoptosis; (tarso) levator resection or advancement, internal approach	Prior Authorization Required	Medical Necessity	Pre Operative Evaluation, History and Physical including functional impairment, and operative report including photos

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
67904	Repair of blepharoptosis; (tarso) levator resection or advancement, external approach	Prior Authorization Required	Medical Necessity	Pre Operative Evaluation, History and Physical including functional impairment, and operative report including photos
67906	Repair of blepharoptosis; superior rectus technique with fascial sling (includes obtaining fascia)	Prior Authorization Required	Medical Necessity	Pre Operative Evaluation, History and Physical including functional impairment, and operative report including photos
67908	Repair of blepharoptosis; conjunctivo-tarso-Muller's muscle-levator resection (eg, Fasanella-Servat type)	Prior Authorization Required	Medical Necessity	Pre Operative Evaluation, History and Physical including functional impairment, and operative report including photos
67950	Canthoplasty (reconstruction of canthus)	Prior Authorization Required	Cosmetic - Reconstructive	Submit history and physical, documentation of medical necessity.
67999	Unlisted procedure, eyelids	Medical necessity review will be performed upon claims submission with supporting documentation.	Medical Necessity	Review required at claims submission; submit description of procedure with supporting documentation (including operative report if surgical) only for the date of service performed.
68399	Unlisted procedure, conjunctiva	Medical necessity review will be performed upon claims submission with supporting documentation.	Medical Necessity	Review required at claims submission; submit description of procedure with supporting documentation (including operative report if surgical) only for the date of service performed.
68899	Unlisted procedure, lacrimal system	Medical necessity review will be performed upon claims submission with supporting documentation.	Medical Necessity	Review required at claims submission; submit description of procedure with supporting documentation (including operative report if surgical) only for the date of service performed.
69090	Ear piercing	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
69300	Otoplasty, protruding ear, with or without size reduction	Possible Denial; Medical Records Optional	Cosmetic	Pre Operative Evaluation, History and Physical including functional impairment, and Operative report

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
69399	Unlisted procedure, external ear	Medical necessity review will be performed upon claims submission with supporting documentation.	Medical Necessity	Review required at claims submission; submit description of procedure with supporting documentation (including operative report if surgical) only for the date of service performed.
69676	Tympanic neurectomy	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
69705	Nasopharyngoscopy, surgical, with dilation of eustachian tube (ie, balloon dilation); unilateral	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity and procedure report.
69706	Nasopharyngoscopy, surgical, with dilation of eustachian tube (ie, balloon dilation); bilateral	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity and procedure report.
69710	Implantation or replacement of electromagnetic bone conduction hearing device in temporal bone	Prior Authorization Required	Medical Necessity	Pre Operative Evaluation, Operative Report, Previous use of hearing aids, Level of hearing Impairment
69711	Removal or repair of electromagnetic bone conduction hearing device in temporal bone	Prior Authorization Required	Medical Necessity	Pre Operative Evaluation, Operative Report, Previous use of hearing aids, Level of hearing Impairment.
69714	Implantation, osseointegrated implant, temporal bone, with percutaneous attachment to external speech processor/cochlear stimulator; without mastoidectomy	Prior Authorization Required	Medical Necessity	Pre Operative Evaluation, Operative Report, Previous use of hearing aids, Level of hearing Impairment
69716	Implantation, osseointegrated implant, skull; with magnetic transcutaneous attachment to external speech processor, within the mastoid and/or resulting in removal of less than 100 sq mm surface area of bone deep to the outer cranial cortex	Prior Authorization Required	Medical Necessity	Pre Operative Evaluation, Operative Report, Previous use of hearing aids, Level of hearing Impairment

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
69717	Replacement (including removal of existing device), osseointegrated implant, skull; with percutaneous attachment to external speech processor	Prior Authorization Required	Medical Necessity	Pre Operative Evaluation, Operative Report, Previous use of hearing aids, Level of hearing Impairment
69719	Replacement (including removal of existing device), osseointegrated implant, skull; with magnetic transcutaneous attachment to external speech processor, within the mastoid and/or involving a bony defect less than 100 sq mm surface area of bone deep to the outer cranial cortex	Prior Authorization Required	Medical Necessity	Pre Operative Evaluation, Operative Report, Previous use of hearing aids, Level of hearing Impairment
69729	Implantation, osseointegrated implant, skull; with magnetic transcutaneous attachment to external speech processor, outside of the mastoid and resulting in removal of greater than or equal to 100 sq mm surface area of bone deep to the outer cranial cortex	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
69730	Replacement (including removal of existing device), osseointegrated implant, skull; with magnetic transcutaneous attachment to external speech processor, outside the mastoid and involving a bony defect greater than or equal to 100 sq mm surface area of bone deep to the outer cranial cortex	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
69799	Unlisted procedure, middle ear	Medical necessity review will be performed upon claims submission with supporting documentation.	Medical Necessity	Review required at claims submission; submit description of procedure with supporting documentation (including operative report if surgical) only for the date of service performed.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
69930	Cochlear device implantation, with or without mastoidectomy	Prior Authorization Required	Medical Necessity	Pre Operative Evaluation, Operative Report, Previous use of hearing aids, Level of hearing Impairment
69949	Unlisted procedure, inner ear	Medical necessity review will be performed upon claims submission with supporting documentation.	Medical Necessity	Review required at claims submission; submit description of procedure with supporting documentation (including operative report if surgical) only for the date of service performed.
69979	Unlisted procedure, temporal bone, middle fossa approach	Medical necessity review will be performed upon claims submission with supporting documentation.	Medical Necessity	Review required at claims submission; submit description of procedure with supporting documentation (including operative report if surgical) only for the date of service performed.
70332	Temporomandibular joint arthrography, radiological supervision and interpretation	Pre-Service Review Required	Medical Necessity	History and physical, documentation of medical necessity, procedure report.
70336	Magnetic resonance (eg, proton) imaging, temporomandibular joint(s)	Prior Authorization Required	Advanced Imaging	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
70450	Computed tomography, head or brain; without contrast material	Prior Authorization Required	Advanced Imaging	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
70460	Computed tomography, head or brain; with contrast material(s)	Prior Authorization Required	Advanced Imaging	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
70470	Computed tomography, head or brain; without contrast material, followed by contrast material(s) and further sections	Prior Authorization Required	Advanced Imaging	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
70480	Computed tomography, orbit, sella, or posterior fossa or outer, middle, or inner ear; without contrast material	Prior Authorization Required	Advanced Imaging	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
70481	Computed tomography, orbit, sella, or posterior fossa or outer, middle, or inner ear; with contrast material(s)	Prior Authorization Required	Advanced Imaging	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
70482	Computed tomography, orbit, sella, or posterior fossa or outer, middle, or inner ear; without contrast material, followed by contrast material(s) and further sections	Prior Authorization Required	Advanced Imaging	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
70486	Computed tomography, maxillofacial area; without contrast material	Prior Authorization Required	Advanced Imaging	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
70487	Computed tomography, maxillofacial area; with contrast material(s)	Prior Authorization Required	Advanced Imaging	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
70488	Computed tomography, maxillofacial area; without contrast material, followed by contrast material(s) and further sections	Prior Authorization Required	Advanced Imaging	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
70490	Computed tomography, soft tissue neck; without contrast material	Prior Authorization Required	Advanced Imaging	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
70491	Computed tomography, soft tissue neck; with contrast material(s)	Prior Authorization Required	Advanced Imaging	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
70492	Computed tomography, soft tissue neck; without contrast material followed by contrast material(s) and further sections	Prior Authorization Required	Advanced Imaging	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
70496	Computed tomographic angiography, head, with contrast material(s), including noncontrast images, if performed, and image postprocessing	Prior Authorization Required	Advanced Imaging	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
70498	Computed tomographic angiography, neck, with contrast material(s), including noncontrast images, if performed, and image postprocessing	Prior Authorization Required	Advanced Imaging	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
70540	Magnetic resonance (eg, proton) imaging, orbit, face, and/or neck; without contrast material(s)	Prior Authorization Required	Advanced Imaging	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
70542	Magnetic resonance (eg, proton) imaging, orbit, face, and/or neck; with contrast material(s)	Prior Authorization Required	Advanced Imaging	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
70543	Magnetic resonance (eg, proton) imaging, orbit, face, and/or neck; without contrast material(s), followed by contrast material(s) and further sequences	Prior Authorization Required	Advanced Imaging	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
70544	Magnetic resonance angiography, head; without contrast material(s)	Prior Authorization Required	Advanced Imaging	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
70545	MRA head; with contrast	Prior Authorization Required	Advanced Imaging	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
70546	Magnetic resonance angiography, head; without contrast material(s), followed by contrast material(s) and further sequences	Prior Authorization Required	Advanced Imaging	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.

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70547	Magnetic resonance angiography, neck; without contrast material(s)	Prior Authorization Required	Advanced Imaging	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
70548	Magnetic resonance angiography, neck; with contrast material(s)	Prior Authorization Required	Advanced Imaging	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
70549	Magnetic resonance angiography, neck; without contrast material(s), followed by contrast material(s) and further sequences	Prior Authorization Required	Advanced Imaging	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
70551	Magnetic resonance (eg, proton) imaging, brain (including brain stem); without contrast material	Prior Authorization Required	Advanced Imaging	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
70552	Magnetic resonance (eg, proton) imaging, brain (including brain stem); with contrast material(s)	Prior Authorization Required	Advanced Imaging	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
70553	Magnetic resonance (eg, proton) imaging, brain (including brain stem); without contrast material, followed by contrast material(s) and further sequences	Prior Authorization Required	Advanced Imaging	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
70554	Magnetic resonance imaging, brain, functional MRI; including test selection and administration of repetitive body part movement and/or visual stimulation, not requiring physician or psychologist administration	Prior Authorization Required	Advanced Imaging	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
70555	Magnetic resonance imaging, brain, functional MRI; requiring physician or psychologist administration of entire neurofunctional testing	Prior Authorization Required	Advanced Imaging	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
71250	Computed tomography, thorax, diagnostic; without contrast material	Prior Authorization Required	Advanced Imaging	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
71260	Computed tomography, thorax, diagnostic; with contrast material(s)	Prior Authorization Required	Advanced Imaging	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
71270	Computed tomography, thorax, diagnostic; without contrast material, followed by contrast material(s) and further sections	Prior Authorization Required	Advanced Imaging	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
71271	Computed tomography, thorax, low dose for lung cancer screening, without contrast material(s)	Prior Authorization Required	Advanced Imaging	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
71275	Computed tomographic angiography, chest (noncoronary), with contrast material(s), including noncontrast images, if performed, and image postprocessing	Prior Authorization Required	Advanced Imaging	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
71550	Magnetic resonance (eg, proton) imaging, chest (eg, for evaluation of hilar and mediastinal lymphadenopathy); without contrast material(s)	Prior Authorization Required	Advanced Imaging	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
71551	Magnetic resonance (eg, proton) imaging, chest (eg, for evaluation of hilar and mediastinal lymphadenopathy); with contrast material(s)	Prior Authorization Required	Advanced Imaging	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
71552	Magnetic resonance (eg, proton) imaging, chest (eg, for evaluation of hilar and mediastinal lymphadenopathy); without contrast material(s), followed by contrast material(s) and further sequences	Prior Authorization Required	Advanced Imaging	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
71555	MRA chest; with or w/o contrast	Prior Authorization Required	Advanced Imaging	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
72125	Computed tomography, cervical spine; without contrast material	Prior Authorization Required	Advanced Imaging	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.

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72126	Computed tomography, cervical spine; with contrast material	Prior Authorization Required	Advanced Imaging	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
72127	Computed tomography, cervical spine; without contrast material, followed by contrast material(s) and further sections	Prior Authorization Required	Advanced Imaging	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
72128	Computed tomography, thoracic spine; without contrast material	Prior Authorization Required	Advanced Imaging	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
72129	Computed tomography, thoracic spine; with contrast material	Prior Authorization Required	Advanced Imaging	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
72130	Computed tomography, thoracic spine; without contrast material, followed by contrast material(s) and further sections	Prior Authorization Required	Advanced Imaging	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
72131	Computed tomography, lumbar spine; without contrast material	Prior Authorization Required	Advanced Imaging	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
72132	Computed tomography, lumbar spine; with contrast material	Prior Authorization Required	Advanced Imaging	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
72133	Computed tomography, lumbar spine; without contrast material, followed by contrast material(s) and further sections	Prior Authorization Required	Advanced Imaging	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
72141	Magnetic resonance (eg, proton) imaging, spinal canal and contents, cervical; without contrast material	Prior Authorization Required	Advanced Imaging	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
72142	Magnetic resonance (eg, proton) imaging, spinal canal and contents, cervical; with contrast material(s)	Prior Authorization Required	Advanced Imaging	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
72146	Magnetic resonance (eg, proton) imaging, spinal canal and contents, thoracic; without contrast material	Prior Authorization Required	Advanced Imaging	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
72147	Magnetic resonance (eg, proton) imaging, spinal canal and contents, thoracic; with contrast material(s)	Prior Authorization Required	Advanced Imaging	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.

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72148	Magnetic resonance (eg, proton) imaging, spinal canal and contents, lumbar; without contrast material	Prior Authorization Required	Advanced Imaging	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
72149	Magnetic resonance (eg, proton) imaging, spinal canal and contents, lumbar; with contrast material(s)	Prior Authorization Required	Advanced Imaging	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
72156	Magnetic resonance (eg, proton) imaging, spinal canal and contents, without contrast material, followed by contrast material(s) and further sequences; cervical	Prior Authorization Required	Advanced Imaging	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
72157	Magnetic resonance (eg, proton) imaging, spinal canal and contents, without contrast material, followed by contrast material(s) and further sequences; thoracic	Prior Authorization Required	Advanced Imaging	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
72158	Magnetic resonance (eg, proton) imaging, spinal canal and contents, without contrast material, followed by contrast material(s) and further sequences; lumbar	Prior Authorization Required	Advanced Imaging	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
72159	Magnetic resonance angiography, spinal canal and contents, with or without contrast material(s)	Prior Authorization Required	Advanced Imaging	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
72191	Computed tomographic angiography, pelvis, with contrast material(s), including noncontrast images, if performed, and image postprocessing	Prior Authorization Required	Advanced Imaging	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
72192	Computed tomography, pelvis; without contrast material	Prior Authorization Required	Advanced Imaging	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
72193	Computed tomography, pelvis; with contrast material(s)	Prior Authorization Required	Advanced Imaging	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
72194	Computed tomography, pelvis; without contrast material, followed by contrast material(s) and further sections	Prior Authorization Required	Advanced Imaging	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
72195	Magnetic resonance (eg, proton) imaging, pelvis; without contrast material(s)	Prior Authorization Required	Advanced Imaging	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
72196	Magnetic resonance (eg, proton) imaging, pelvis; with contrast material(s)	Prior Authorization Required	Advanced Imaging	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
72197	Magnetic resonance (eg, proton) imaging, pelvis; without contrast material(s), followed by contrast material(s) and further sequences	Prior Authorization Required	Advanced Imaging	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
72198	Magnetic resonance angiography, pelvis, with or without contrast material(s)	Prior Authorization Required	Advanced Imaging	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
73200	Computed tomography, upper extremity; without contrast material	Prior Authorization Required	Advanced Imaging	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
73201	Computed tomography, upper extremity; with contrast material(s)	Prior Authorization Required	Advanced Imaging	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
73202	Computed tomography, upper extremity; without contrast material, followed by contrast material(s) and further sections	Prior Authorization Required	Advanced Imaging	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
73206	Computed tomographic angiography, upper extremity, with contrast material(s), including noncontrast images, if performed, and image postprocessing	Prior Authorization Required	Advanced Imaging	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
73218	Magnetic resonance (eg, proton) imaging, upper extremity, other than joint; without contrast material(s)	Prior Authorization Required	Advanced Imaging	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
73219	Magnetic resonance (eg, proton) imaging, upper extremity, other than joint; with contrast material(s)	Prior Authorization Required	Advanced Imaging	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
73220	Magnetic resonance (eg, proton) imaging, upper extremity, other than joint; without contrast material(s), followed by contrast material(s) and further sequences	Prior Authorization Required	Advanced Imaging	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
73221	Magnetic resonance (eg, proton) imaging, any joint of upper extremity; without contrast material(s)	Prior Authorization Required	Advanced Imaging	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
73222	Magnetic resonance (eg, proton) imaging, any joint of upper extremity; with contrast material(s)	Prior Authorization Required	Advanced Imaging	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
73223	Magnetic resonance (eg, proton) imaging, any joint of upper extremity; without contrast material(s), followed by contrast material(s) and further sequences	Prior Authorization Required	Advanced Imaging	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
73225	Magnetic resonance angiography, upper extremity, with or without contrast material(s)	Prior Authorization Required	Advanced Imaging	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
73700	Computed tomography, lower extremity; without contrast material	Prior Authorization Required	Advanced Imaging	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
73701	Computed tomography, lower extremity; with contrast material(s)	Prior Authorization Required	Advanced Imaging	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
73702	Computed tomography, lower extremity; without contrast material, followed by contrast material(s) and further sections	Prior Authorization Required	Advanced Imaging	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
73706	Computed tomographic angiography, lower extremity, with contrast material(s), including noncontrast images, if performed, and image postprocessing	Prior Authorization Required	Advanced Imaging	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
73718	Magnetic resonance (eg, proton) imaging, lower extremity other than joint; without contrast material(s)	Prior Authorization Required	Advanced Imaging	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.

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73719	Magnetic resonance (eg, proton) imaging, lower extremity other than joint; with contrast material(s)	Prior Authorization Required	Advanced Imaging	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
73720	Magnetic resonance (eg, proton) imaging, lower extremity other than joint; without contrast material(s), followed by contrast material(s) and further sequences	Prior Authorization Required	Advanced Imaging	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
73721	Magnetic resonance (eg, proton) imaging, any joint of lower extremity; without contrast material	Prior Authorization Required	Advanced Imaging	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
73722	Magnetic resonance (eg, proton) imaging, any joint of lower extremity; with contrast material(s)	Prior Authorization Required	Advanced Imaging	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
73723	Magnetic resonance (eg, proton) imaging, any joint of lower extremity; without contrast material(s), followed by contrast material(s) and further sequences	Prior Authorization Required	Advanced Imaging	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
73725	Magnetic resonance angiography, lower extremity, with or without contrast material(s)	Prior Authorization Required	Advanced Imaging	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.

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74150	Computed tomography, abdomen; without contrast material	Prior Authorization Required	Advanced Imaging	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
74160	Computed tomography, abdomen; with contrast material(s)	Prior Authorization Required	Advanced Imaging	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
74170	Computed tomography, abdomen; without contrast material, followed by contrast material(s) and further sections	Prior Authorization Required	Advanced Imaging	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
74174	Computed tomographic angiography, abdomen and pelvis, with contrast material(s), including noncontrast images, if performed, and image postprocessing	Prior Authorization Required	Advanced Imaging	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
74175	Computed tomographic angiography, abdomen, with contrast material(s), including noncontrast images, if performed, and image postprocessing	Prior Authorization Required	Advanced Imaging	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
74176	Computed tomography, abdomen and pelvis; without contrast material	Prior Authorization Required	Advanced Imaging	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
74177	Computed tomography, abdomen and pelvis; with contrast material(s)	Prior Authorization Required	Advanced Imaging	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
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 Required	Advanced Imaging	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
74181	Magnetic resonance (eg, proton) imaging, abdomen; without contrast material(s)	Prior Authorization Required	Advanced Imaging	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
74182	Magnetic resonance (eg, proton) imaging, abdomen; with contrast material(s)	Prior Authorization Required	Advanced Imaging	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
74183	Magnetic resonance (eg, proton) imaging, abdomen; without contrast material(s), followed by with contrast material(s) and further sequences	Prior Authorization Required	Advanced Imaging	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
74185	Magnetic resonance angiography, abdomen, with or without contrast material(s)	Prior Authorization Required	Advanced Imaging	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
74261	Computed tomographic (CT) colonography, diagnostic, including image postprocessing; without contrast material	Prior Authorization Required	Advanced Imaging	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
74262	Computed tomographic (CT) colonography, diagnostic, including image postprocessing; with contrast material(s) including non-contrast images, if performed	Prior Authorization Required	Advanced Imaging	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
74263	Computed tomographic (CT) colonography, screening, including image postprocessing	Prior Authorization Required	Advanced Imaging	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
74712	Magnetic resonance (eg, proton) imaging, fetal, including placental and maternal pelvic imaging when performed; single or first gestation	Prior Authorization Required	Advanced Imaging	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
75557	Cardiac magnetic resonance imaging for morphology and function without contrast material;	Prior Authorization Required	Advanced Imaging	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
75559	Cardiac magnetic resonance imaging for morphology and function without contrast material; with stress imaging	Prior Authorization Required	Advanced Imaging	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
75561	Cardiac magnetic resonance imaging for morphology and function without contrast material(s), followed by contrast material(s) and further sequences;	Prior Authorization Required	Advanced Imaging	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
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 Required	Advanced Imaging	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
75565	Cardiac magnetic resonance imaging for velocity flow mapping (List separately in addition to code for primary procedure)	Prior Authorization Required	Advanced Imaging	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
75571	Computed tomography, heart, without contrast material, with quantitative evaluation of coronary calcium	Prior Authorization Required	Advanced Imaging	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
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 Required	Advanced Imaging	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
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 LV cardiac function, RV structure and function)	Prior Authorization Required	Advanced Imaging	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
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)	Prior Authorization Required	Advanced Imaging	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
75580	Noninvasive estimate of coronary fractional flow reserve derived from augmentative software analysis of the data set from a coronary computed tomography angiography	Prior Authorization Required	Advanced Imaging	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
75635	Computed tomographic angiography, abdominal aorta and bilateral iliofemoral lower extremity runoff, with contrast material(s), including noncontrast images, if performed, and image postprocessing	Prior Authorization Required	Advanced Imaging	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
75894	Transcatheter therapy, embolization, any method, radiological supervision and interpretation	Prior Authorization Required	Medical Necessity	History and Physical, including prior treatment regimens.
76014	MR safety implant and/or foreign body assessment by trained clinical staff, including identification and verification of implant components from appropriate sources (eg, surgical reports, imaging reports, medical device databases, device vendors, review of prior imaging), analyzing current MR conditional status of individual components and systems, and consulting published professional guidance with written report; initial 15 minutes	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
76015	MR safety implant and/or foreign body assessment by trained clinical staff, including identification and verification of implant components from appropriate sources (eg, surgical reports, imaging reports, medical device databases, device vendors, review of prior imaging), analyzing current MR conditional status of individual components and systems, and consulting published professional guidance with written report; each additional 30 minutes (List separately in addition to code for primary procedure)	Non-covered Service	Not Covered	This service is not covered by the member's contract.
76016	MR safety determination by a physician or other qualified health care professional responsible for the safety of the MR procedure, including review of implant MR conditions for indicated MR examination, analysis of risk vs clinical benefit of performing MR examination, and determination of MR equipment, accessory equipment, and expertise required to perform examination, with written report	Non-covered Service	Not Covered	This service is not covered by the member's contract.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
76017	MR safety medical physics examination customization, planning and performance monitoring by medical physicist or MR safety expert, with review and analysis by physician or other qualified health care professional to prioritize and select views and imaging sequences, to tailor MR acquisition specific to restrictive requirements or artifacts associated with MR conditional implants or to mitigate risk of non-conditional implants or foreign bodies, with written report	Non-covered Service	Not Covered	This service is not covered by the member's contract.
76018	MR safety implant electronics preparation under supervision of physician or other qualified health care professional, including MR-specific programming of pulse generator and/or transmitter to verify device integrity, protection of device internal circuitry from MR electromagnetic fields, and protection of patient from risks of unintended stimulation or heating while in the MR room, with written report	Non-covered Service	Not Covered	This service is not covered by the member's contract.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
76019	MR safety implant positioning and/or immobilization under supervision of physician or other qualified health care professional, including application of physical protections to secure implanted medical device from MR-induced translational or vibrational forces, magnetically induced functional changes, and/or prevention of radiofrequency burns from inadvertent tissue contact while in the MR room, with written report	Non-covered Service	Not Covered	This service is not covered by the member's contract.
76120	Cineradiography/videoradiography, except where specifically included	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
76125	Cineradiography/videoradiography to complement routine examination (List separately in addition to code for primary procedure)	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
76390	Magnetic resonance spectroscopy	Prior Authorization Required	Advanced Imaging	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
76391	Magnetic resonance (eg, vibration) elastography	Prior Authorization Required	Advanced Imaging	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
76496	Unlisted fluoroscopic procedure (eg, diagnostic, interventional)	Medical necessity review will be performed upon claims submission with supporting documentation.	Medical Necessity	Upon claims submission Medical necessity review will be performed. Submit documentation to describe the services. Include Office Notes from ordering physician related to a billed services and radiology report.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
76498	Unlisted magnetic resonance procedure (eg, diagnostic, interventional)	Medical necessity review will be performed upon claims submission with supporting documentation.	Medical Necessity	Review required at claims submission; submit description of procedure with supporting documentation (including operative report if surgical) only for the date of service performed.
76499	Unlisted diagnostic radiographic procedure	Medical necessity review will be performed upon claims submission with supporting documentation.	Medical Necessity	Upon claims submission Medical necessity review will be performed. Submit documentation to describe the services. Include Office Notes from ordering physician related to a billed services and radiology report.
76873	Ultrasound, transrectal; prostate volume study for brachytherapy treatment planning (separate procedure)	Prior Authorization Required	Radiation Oncology	No review for non-cancer diagnoses. FOR CANCER DIAGNOSES ONLY: Submit online review with Carelon at www.providerportal.com. For prior authorization include history and physical, results of previous diagnostics procedure report.
76965	Ultrasonic guidance for interstitial radioelement application	Prior Authorization Required	Radiation Oncology	No review for non-cancer diagnoses. FOR CANCER DIAGNOSES ONLY: Submit online review with Carelon at www.providerportal.com. For prior authorization include history and physical, results of previous diagnostics procedure report.
76999	Unlisted ultrasound procedure (eg, diagnostic, interventional)	Medical necessity review will be performed upon claims submission with supporting documentation.	Medical Necessity	Review required at claims submission; submit description of procedure with supporting documentation (including operative report if surgical) only for the date of service performed.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
77014	Computed tomography guidance for placement of radiation therapy fields	Prior Authorization Required	Radiation Oncology	For cancer diagnoses only: Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
77046	Magnetic resonance imaging, breast, without contrast material; unilateral	Prior Authorization Required	Advanced Imaging	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
77047	Magnetic resonance imaging, breast, without contrast material; bilateral	Prior Authorization Required	Advanced Imaging	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
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 Required	Advanced Imaging	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
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 Required	Advanced Imaging	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
77078	Computed tomography, bone mineral density study, 1 or more sites; axial skeleton (eg, hips, pelvis, spine)	Prior Authorization Required	Advanced Imaging	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.

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77084	Magnetic resonance (eg, proton) imaging, bone marrow blood supply	Prior Authorization Required	Advanced Imaging	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
77295	3-dimensional radiotherapy plan, including dose-volume histograms	Prior Authorization Required	Radiation Oncology	No review for non-cancer diagnoses. REVIEWED ONLY for BONE METs, FEMALE BREAST, MALE BREAST, NON-SMALL LUNG CELL CANCER or PROSTATE CANCER DIAGNOSES: Submit online review with Carelon at www.providerportal.com. For prior authorization include history and physical, results of previous diagnostics procedure report.
77299	Unlisted procedure, therapeutic radiology clinical treatment planning	Medical necessity review will be performed upon claims submission with supporting documentation.	Medical Necessity	Review required at claims submission; submit description of procedure with supporting documentation (including operative report if surgical) only for the date of service performed.
77301	Intensity modulated radiotherapy plan including dose-volume histograms for target and critical structure partial tolerance specifications	Prior Authorization Required	Radiation Oncology	No review for non-cancer diagnoses. FOR CANCER DIAGNOSES ONLY: Submit online review with Carelon at www.providerportal.com. For prior authorization include history and physical, results of previous diagnostics procedure report.
77316	Brachytherapy isodose plan; simple (calculation[s] made from 1 to 4 sources, or remote afterloading brachytherapy, 1 channel), includes basic dosimetry calculation(s)	Prior Authorization Required	Radiation Oncology	No review for non-cancer diagnoses. FOR CANCER DIAGNOSES ONLY: Submit online review with Carelon at www.providerportal.com. For prior authorization include history and physical, results of previous diagnostics procedure report.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
77317	Brachytherapy isodose plan; intermediate (calculation[s] made from 5 to 10 sources, or remote afterloading brachytherapy, 2-12 channels), includes basic dosimetry calculation(s)	Prior Authorization Required	Radiation Oncology	No review for non-cancer diagnoses. FOR CANCER DIAGNOSES ONLY: Submit online review with Carelon at www.providerportal.com. For prior authorization include history and physical, results of previous diagnostics procedure report.
77318	Brachytherapy isodose plan; complex (calculation[s] made from over 10 sources, or remote afterloading brachytherapy, over 12 channels), includes basic dosimetry calculation(s)	Prior Authorization Required	Radiation Oncology	No review for non-cancer diagnoses. FOR CANCER DIAGNOSES ONLY: Submit online review with Carelon at www.providerportal.com. For prior authorization include history and physical, results of previous diagnostics procedure report.
77338	Multi-leaf collimator (MLC) device(s) for intensity modulated radiation therapy (IMRT), design and construction per IMRT plan	Prior Authorization Required	Radiation Oncology	No review for non-cancer diagnoses. FOR CANCER DIAGNOSES ONLY: Submit online review with Carelon at www.providerportal.com. For prior authorization include history and physical, results of previous diagnostics procedure report.
77370	Special medical radiation physics consultation	Prior Authorization Required	Radiation Oncology	For cancer diagnosis only: Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
77371	Radiation treatment delivery, stereotactic radiosurgery (SRS), complete course of treatment of cerebral lesion(s) consisting of 1 session; multisource Cobalt 60 based or more lesions, including image guidance, entire course not to exceed 5 fractions	Prior Authorization Required	Radiation Oncology	No review for non-cancer diagnoses. FOR CANCER DIAGNOSES ONLY: Submit online review with Carelon at www.providerportal.com. For prior authorization include history and physical, results of previous diagnostics procedure report.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
77372	Radiation treatment delivery, stereotactic radiosurgery (SRS), complete course of treatment of cranial lesion(s) consisting of 1 session; linear accelerator based	Prior Authorization Required	Radiation Oncology	No review for non-cancer diagnoses. FOR CANCER DIAGNOSES ONLY: Submit online review with Carelon at www.providerportal.com. For prior authorization include history and physical, results of previous diagnostics procedure report.
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 Required	Radiation Oncology	No review for non-cancer diagnoses. FOR CANCER DIAGNOSES ONLY: Submit online review with Carelon at www.providerportal.com. For prior authorization include history and physical, results of previous diagnostics procedure report.
77385	Intensity modulated radiation treatment delivery (IMRT), includes guidance and tracking, when performed; simple	Prior Authorization Required	Radiation Oncology	No review for non-cancer diagnoses. FOR CANCER DIAGNOSES ONLY: Submit online review with Carelon at www.providerportal.com. For prior authorization include history and physical, results of previous diagnostics procedure report.
77386	Intensity modulated radiation treatment delivery (IMRT), includes guidance and tracking, when performed; complex	Prior Authorization Required	Radiation Oncology	No review for non-cancer diagnoses. FOR CANCER DIAGNOSES ONLY: Submit online review with Carelon at www.providerportal.com. For prior authorization include history and physical, results of previous diagnostics procedure report.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
77387	Guidance for localization of target volume for delivery of radiation treatment, includes intrafraction tracking, when performed	Prior Authorization Required	Radiation Oncology	No review for non-cancer diagnoses. FOR CANCER DIAGNOSES ONLY: Submit online review with Carelon at www.providerportal.com. For prior authorization include history and physical, results of previous diagnostics procedure report.
77399	Unlisted procedure, medical radiation physics, dosimetry and treatment devices, and special services	Medical necessity review will be performed upon claims submission with supporting documentation.	Medical Necessity	Review required at claims submission; submit description of procedure with supporting documentation (including operative report if surgical) only for the date of service performed.
77402	Radiation treatment delivery,=>1 MeV; simple	Prior Authorization Required	Radiation Oncology	No review for non-cancer diagnoses. REVIEWED ONLY for BONE METs, FEMALE BREAST, MALE BREAST, NON-SMALL LUNG CELL CANCER or PROSTATE CANCER DIAGNOSES: Submit online review with Carelon at www.providerportal.com. For prior authorization include history and physical, results of previous diagnostics procedure report.
77407	Radiation treatment delivery, =>1 MeV; intermediate	Prior Authorization Required	Radiation Oncology	No review for non-cancer diagnoses. REVIEWED ONLY for BONE METs, FEMALE BREAST, MALE BREAST, NON-SMALL LUNG CELL CANCER or PROSTATE CANCER DIAGNOSES: Submit online review with Carelon at www.providerportal.com. For prior authorization include history and physical, results of previous diagnostics procedure report.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
77412	Radiation treatment delivery, =>1 MeV; complex	Prior Authorization Required	Radiation Oncology	No review for non-cancer diagnoses. REVIEWED ONLY for BONE METs, FEMALE BREAST, MALE BREAST, NON-SMALL LUNG CELL CANCER or PROSTATE CANCER DIAGNOSES: Submit online review with Carelon at www.providerportal.com. For prior authorization include history and physical, results of previous diagnostics procedure report.
77424	Intraoperative radiation treatment delivery, x-ray, single treatment session	Prior Authorization Required	Radiation Oncology	No review for non-cancer diagnoses. FOR CANCER DIAGNOSES ONLY: Submit online review with Carelon at www.providerportal.com. For prior authorization include history and physical, results of previous diagnostics procedure report.
77425	Intraoperative radiation treatment delivery, electrons, single treatment session	Prior Authorization Required	Radiation Oncology	No review for non-cancer diagnoses. FOR CANCER DIAGNOSES ONLY: Submit online review with Carelon at www.providerportal.com. For prior authorization include history and physical, results of previous diagnostics procedure report.
77432	Stereotactic radiation treatment management of cranial lesion(s) (complete course of treatment consisting of 1 session)	Prior Authorization Required	Radiation Oncology	No review for non-cancer diagnoses. FOR CANCER DIAGNOSES ONLY: Submit online review with Carelon at www.providerportal.com. For prior authorization include history and physical, results of previous diagnostics procedure report.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
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 Required	Radiation Oncology	No review for non-cancer diagnoses. FOR CANCER DIAGNOSES ONLY: Submit online review with Carelon at www.providerportal.com. For prior authorization include history and physical, results of previous diagnostics procedure report.
77469	Intraoperative radiation treatment management	Prior Authorization Required	Radiation Oncology	No review for non-cancer diagnoses. FOR CANCER DIAGNOSES ONLY: Submit online review with Carelon at www.providerportal.com. For prior authorization include history and physical, results of previous diagnostics procedure report.
77470	Special treatment procedure (eg, total body irradiation, hemibody radiation, per oral or endocavitary irradiation)	Prior Authorization Required	Radiation Oncology	No review for non-cancer diagnoses. FOR CANCER DIAGNOSES ONLY: Submit online review with Carelon at www.providerportal.com. For prior authorization include history and physical, results of previous diagnostics procedure report.
77499	Unlisted procedure, therapeutic radiology treatment management	Medical necessity review will be performed upon claims submission with supporting documentation.	Medical Necessity	Review required at claims submission; submit description of procedure with supporting documentation (including operative report if surgical) only for the date of service performed.
77520	Proton treatment delivery; simple, without compensation	Prior Authorization Required	Radiation Oncology	No review for non-cancer diagnoses. FOR CANCER DIAGNOSES ONLY: Submit online review with Carelon at www.providerportal.com. For prior authorization include history and physical, results of previous diagnostics procedure report.

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77522	Proton treatment delivery; simple, with compensation	Prior Authorization Required	Radiation Oncology	No review for non-cancer diagnoses. FOR CANCER DIAGNOSES ONLY: Submit online review with Carelon at www.providerportal.com. For prior authorization include history and physical, results of previous diagnostics procedure report.
77523	Proton treatment delivery; intermediate	Prior Authorization Required	Radiation Oncology	No review for non-cancer diagnoses. FOR CANCER DIAGNOSES ONLY: Submit online review with Carelon at www.providerportal.com. For prior authorization include history and physical, results of previous diagnostics procedure report.
77525	Proton treatment delivery; complex	Prior Authorization Required	Radiation Oncology	No review for non-cancer diagnoses. FOR CANCER DIAGNOSES ONLY: Submit online review with Carelon at www.providerportal.com. For prior authorization include history and physical, results of previous diagnostics procedure report.
77761	Intracavitary radiation source application; simple	Prior Authorization Required	Radiation Oncology	No review for non-cancer diagnoses. FOR CANCER DIAGNOSES ONLY: Submit online review with Carelon at www.providerportal.com. For prior authorization include history and physical, results of previous diagnostics procedure report.

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77762	Intracavitary radiation source application; intermediate	Prior Authorization Required	Radiation Oncology	No review for non-cancer diagnoses. FOR CANCER DIAGNOSES ONLY: Submit online review with Carelon at www.providerportal.com. For prior authorization include history and physical, results of previous diagnostics procedure report.
77763	Intracavitary radiation source application; complex	Prior Authorization Required	Radiation Oncology	No review for non-cancer diagnoses. FOR CANCER DIAGNOSES ONLY: Submit online review with Carelon at www.providerportal.com. For prior authorization include history and physical, results of previous diagnostics procedure report.
77767	Remote afterloading high dose rate radionuclide skin surface brachytherapy, includes basic dosimetry, when performed; lesion diameter up to 2.0 cm or 1 channel	Prior Authorization Required	Radiation Oncology	No review for non-cancer diagnoses. FOR CANCER DIAGNOSES ONLY: Submit online review with Carelon at www.providerportal.com. For prior authorization include history and physical, results of previous diagnostics procedure report.
77768	Remote afterloading high dose rate radionuclide skin surface brachytherapy, includes basic dosimetry, when performed; lesion diameter over 2.0 cm and 2 or more channels, or multiple lesions	Prior Authorization Required	Radiation Oncology	No review for non-cancer diagnoses. FOR CANCER DIAGNOSES ONLY: Submit online review with Carelon at www.providerportal.com. For prior authorization include history and physical, results of previous diagnostics procedure report.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
77770	Remote afterloading high dose rate radionuclide interstitial or intracavitary brachytherapy, includes basic dosimetry, when performed; 1 channel	Prior Authorization Required	Radiation Oncology	No review for non-cancer diagnoses. FOR CANCER DIAGNOSES ONLY: Submit online review with Carelon at www.providerportal.com. For prior authorization include history and physical, results of previous diagnostics procedure report.
77771	Remote afterloading high dose rate radionuclide interstitial or intracavitary brachytherapy, includes basic dosimetry, when performed; 2-12 channels	Prior Authorization Required	Radiation Oncology	No review for non-cancer diagnoses. FOR CANCER DIAGNOSES ONLY: Submit online review with Carelon at www.providerportal.com. For prior authorization include history and physical, results of previous diagnostics procedure report.
77772	Remote afterloading high dose rate radionuclide interstitial or intracavitary brachytherapy, includes basic dosimetry, when performed; over 12 channels	Prior Authorization Required	Radiation Oncology	No review for non-cancer diagnoses. FOR CANCER DIAGNOSES ONLY: Submit online review with Carelon at www.providerportal.com. For prior authorization include history and physical, results of previous diagnostics procedure report.
77778	Interstitial radiation source application, complex, includes supervision, handling, loading of radiation source, when performed	Prior Authorization Required	Radiation Oncology	No review for non-cancer diagnoses. FOR CANCER DIAGNOSES ONLY: Submit online review with Carelon at www.providerportal.com. For prior authorization include history and physical, results of previous diagnostics procedure report.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
77790	Supervision, handling, loading of radiation source	Prior Authorization Required	Radiation Oncology	No review for non-cancer diagnoses. FOR CANCER DIAGNOSES ONLY: Submit online review with Carelon at www.providerportal.com. For prior authorization include history and physical, results of previous diagnostics procedure report.
77799	Unlisted procedure, clinical brachytherapy	Medical necessity review will be performed upon claims submission with supporting documentation.	Medical Necessity	Review required at claims submission; submit description of procedure with supporting documentation (including operative report if surgical) only for the date of service performed.
78099	Unlisted endocrine procedure, diagnostic nuclear medicine	Medical necessity review will be performed upon claims submission with supporting documentation.	Medical Necessity	Review required at claims submission; submit description of procedure with supporting documentation (including operative report if surgical) only for the date of service performed.
78199	Unlisted hematopoietic, reticuloendothelial and lymphatic procedure, diagnostic nuclear medicine	Medical necessity review will be performed upon claims submission with supporting documentation.	Medical Necessity	Review required at claims submission; submit description of procedure with supporting documentation (including operative report if surgical) only for the date of service performed.
78299	Unlisted gastrointestinal procedure, diagnostic nuclear medicine	Medical necessity review will be performed upon claims submission with supporting documentation.	Medical Necessity	Review required at claims submission; submit description of procedure with supporting documentation (including operative report if surgical) only for the date of service performed.
78399	Unlisted musculoskeletal procedure, diagnostic nuclear medicine	Medical necessity review will be performed upon claims submission with supporting documentation.	Medical Necessity	Review required at claims submission; submit description of procedure with supporting documentation (including operative report if surgical) only for the date of service performed.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
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 Required	Advanced Imaging	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
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 Required	Advanced Imaging	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
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 Required	Advanced Imaging	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
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 Required	Advanced Imaging	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
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 Required	Advanced Imaging	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
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	Prior Authorization Required	Advanced Imaging	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
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	Prior Authorization Required	Advanced Imaging	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
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 Required	Advanced Imaging	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
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	Prior Authorization Required	Advanced Imaging	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
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 Required	Advanced Imaging	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
78466	Myocardial imaging, infarct avid, planar; qualitative or quantitative	Prior Authorization Required	Advanced Imaging	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
78468	Myocardial imaging, infarct avid, planar; with ejection fraction by first pass technique	Prior Authorization Required	Advanced Imaging	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
78469	Myocardial imaging, infarct avid, planar; tomographic SPECT with or without quantification	Prior Authorization Required	Advanced Imaging	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
78472	Cardiac blood pool imaging, gated equilibrium; planar, single study at rest or stress (exercise and/or pharmacologic), wall motion study plus ejection fraction, with or without additional quantitative processing	Prior Authorization Required	Advanced Imaging	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.

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78473	Cardiac blood pool imaging, gated equilibrium; multiple studies, wall motion study plus ejection fraction, at rest and stress (exercise and/or pharmacologic), with or without additional quantification	Prior Authorization Required	Advanced Imaging	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
78481	Cardiac blood pool imaging (planar), first pass technique; single study, at rest or with stress (exercise and/or pharmacologic), wall motion study plus ejection fraction, with or without quantification	Prior Authorization Required	Advanced Imaging	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
78483	Cardiac blood pool imaging (planar), first pass technique; multiple studies, at rest and with stress (exercise and/ or pharmacologic), wall motion study plus ejection fraction, with or without quantification	Prior Authorization Required	Advanced Imaging	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
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 Required	Advanced Imaging	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
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 stress (exercise or pharmacologic)	Prior Authorization Required	Advanced Imaging	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
78494	Cardiac blood pool imaging, gated equilibrium, SPECT, at rest, wall motion study plus ejection fraction, with or without quantitative processing	Prior Authorization Required	Advanced Imaging	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.

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78499	Unlisted cardiovascular procedure, diagnostic nuclear medicine	Medical necessity review will be performed upon claims submission with supporting documentation.	Medical Necessity	Review required at claims submission; submit description of procedure with supporting documentation (including operative report if surgical) only for the date of service performed.
78599	Unlisted respiratory procedure, diagnostic nuclear medicine	Medical necessity review will be performed upon claims submission with supporting documentation.	Medical Necessity	Review required at claims submission; submit description of procedure with supporting documentation (including operative report if surgical) only for the date of service performed.
78608	Brain imaging, positron emission tomography (PET); metabolic evaluation	Prior Authorization Required	Advanced Imaging	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
78609	Brain imaging, positron emission tomography (PET); perfusion evaluation	Prior Authorization Required	Advanced Imaging	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
78699	Unlisted nervous system procedure, diagnostic nuclear medicine	Medical necessity review will be performed upon claims submission with supporting documentation.	Medical Necessity	Review required at claims submission; submit description of procedure with supporting documentation (including operative report if surgical) only for the date of service performed.
78799	Unlisted genitourinary procedure, diagnostic nuclear medicine	Medical necessity review will be performed upon claims submission with supporting documentation.	Medical Necessity	Review required at claims submission; submit description of procedure with supporting documentation (including operative report if surgical) only for the date of service performed.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
78811	Positron emission tomography (PET) imaging; limited area (eg, chest, head/neck)	Prior Authorization Required	Advanced Imaging	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
78812	Positron emission tomography (PET) imaging; skull base to mid-thigh	Prior Authorization Required	Advanced Imaging	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
78813	Positron emission tomography (PET) imaging; whole body	Prior Authorization Required	Advanced Imaging	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
78814	Positron emission tomography (PET) with concurrently acquired computed tomography (CT) for attenuation correction and anatomical localization imaging; limited area (eg, chest, head/neck)	Prior Authorization Required	Advanced Imaging	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
78815	Positron emission tomography (PET) with concurrently acquired computed tomography (CT) for attenuation correction and anatomical localization imaging; skull base to mid-thigh	Prior Authorization Required	Advanced Imaging	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report. No review needed when billed with code A9588.
78816	Positron emission tomography (PET) with concurrently acquired computed tomography (CT) for attenuation correction and anatomical localization imaging; whole body	Prior Authorization Required	Advanced Imaging	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report. No review needed when billed with code A9588.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
78999	Unlisted miscellaneous procedure, diagnostic nuclear medicine	Medical necessity review will be performed upon claims submission with supporting documentation.	Medical Necessity	Review required at claims submission; submit description of procedure with supporting documentation (including operative report if surgical) only for the date of service performed.
79445	Radiopharmaceutical therapy, by intra-arterial particulate administration	Prior Authorization Required	Medical Necessity	Submit History and Physical, documentation of medical necessity, treatment plan, procedure report
79999	Radiopharmaceutical therapy, unlisted procedure	Medical necessity review will be performed upon claims submission with supporting documentation.	Medical Necessity	Review required at claims submission; submit description of procedure with supporting documentation (including operative report if surgical) only for the date of service performed.
80299	Quantitation of therapeutic drug, not elsewhere specified	Medical necessity review will be performed upon claims submission with supporting documentation.	Medical Necessity	Review required at claims submission; submit description of procedure with supporting documentation (including operative report if surgical) only for the date of service performed.
81099	Unlisted urinalysis procedure	Medical necessity review will be performed upon claims submission with supporting documentation.	Medical Necessity	Review required at claims submission; submit description of procedure with supporting documentation (including operative report if surgical) only for the date of service performed.
81120	IDH1 (isocitrate dehydrogenase 1 [NADP+], soluble) (eg, glioma), common variants (eg, R132H, R132C)	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. WA PLAN MEMBERS ONLY: No prior authorization required for requests related to stage 3 or 4 cancer; or remittent, recurrent, relapsed, or metastatic cancers. Post-service review may be required through Carelon.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
81121	IDH2 (isocitrate dehydrogenase 2 [NADP+], mitochondrial) (eg, glioma), common variants (eg, R140W, R172M)	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. WA PLAN MEMBERS ONLY: No prior authorization required for requests related to stage 3 or 4 cancer; or remittent, recurrent, relapsed, or metastatic cancers. Post-service review may be required through Carelon.
81161	DMD (dystrophin) (eg, Duchenne/Becker muscular dystrophy) deletion analysis, and duplication analysis, if performed	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
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 Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. WA PLAN MEMBERS ONLY: No prior authorization required for requests related to stage 3 or 4 cancer; or remittent, recurrent, relapsed, or metastatic cancers. Post-service review may be required through Carelon.
81163	BRCA1 (BRCA1, DNA repair associated), BRCA2 (BRCA2, DNA repair associated) (eg, hereditary breast and ovarian cancer) gene analysis; full sequence analysis	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. WA PLAN MEMBERS ONLY: No prior authorization required for requests related to stage 3 or 4 cancer; or remittent, recurrent, relapsed, or metastatic cancers. Post-service review may be required through Carelon.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
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 Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. WA PLAN MEMBERS ONLY: No prior authorization required for requests related to stage 3 or 4 cancer; or remittent, recurrent, relapsed, or metastatic cancers. Post-service review may be required through Carelon.
81165	BRCA1 (BRCA1, DNA repair associated) (eg, hereditary breast and ovarian cancer) gene analysis; full sequence analysis	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. WA PLAN MEMBERS ONLY: No prior authorization required for requests related to stage 3 or 4 cancer; or remittent, recurrent, relapsed, or metastatic cancers. Post-service review may be required through Carelon.
81166	BRCA1 (BRCA1, DNA repair associated) (eg, hereditary breast and ovarian cancer) gene analysis; full duplication/deletion analysis (ie, detection of large gene rearrangements)	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. WA PLAN MEMBERS ONLY: No prior authorization required for requests related to stage 3 or 4 cancer; or remittent, recurrent, relapsed, or metastatic cancers. Post-service review may be required through Carelon.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
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 Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. WA PLAN MEMBERS ONLY: No prior authorization required for requests related to stage 3 or 4 cancer; or remittent, recurrent, relapsed, or metastatic cancers. Post-service review may be required through Carelon.
81168	CCND1/IGH (t(11;14)) (eg, mantle cell lymphoma) translocation analysis, major breakpoint, qualitative and quantitative, if performed	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. WA PLAN MEMBERS ONLY: No prior authorization required for requests related to stage 3 or 4 cancer; or remittent, recurrent, relapsed, or metastatic cancers. Post-service review may be required through Carelon.
81170	ABL1 (ABL proto-oncogene 1, non-receptor tyrosine kinase) (eg, acquired imatinib tyrosine kinase inhibitor resistance), gene analysis, variants in the kinase domain	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. WA PLAN MEMBERS ONLY: No prior authorization required for requests related to stage 3 or 4 cancer; or remittent, recurrent, relapsed, or metastatic cancers. Post-service review may be required through Carelon.
81171	AFF2 (ALF transcription elongation factor 2 (FMR2) (EF, Fragile X intellectual disability 2 (FRAXE) gene analysis; evaluation to detect abnormal (eg, expanded) alleles	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.

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81172	AFF2 (ALF transcription elongation factor 2 (FMR2) (EF, fragile X intellectual disability 2 (FRAXE) gene analysis; characterization of alleles (eg, expanded size and methylation status)	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
81173	AR (androgen receptor) (eg, spinal and bulbar muscular atrophy, Kennedy disease, X chromosome inactivation) gene analysis; full gene sequence	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
81174	AR (androgen receptor) (eg, spinal and bulbar muscular atrophy, Kennedy disease, X chromosome inactivation) gene analysis; known familial variant	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
81175	ASXL1 (additional sex combs like 1, transcriptional regulator) (eg, myelodysplastic syndrome, myeloproliferative neoplasms, chronic myelomonocytic leukemia), gene analysis; full gene sequence	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. WA PLAN MEMBERS ONLY: No prior authorization required for requests related to stage 3 or 4 cancer; or remittent, recurrent, relapsed, or metastatic cancers. Post-service review may be required through Carelon.
81176	ASXL1 (additional sex combs like 1, transcriptional regulator) (eg, myelodysplastic syndrome, myeloproliferative neoplasms, chronic myelomonocytic leukemia), gene analysis; targeted sequence analysis (eg, exon 12)	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. WA PLAN MEMBERS ONLY: No prior authorization required for requests related to stage 3 or 4 cancer; or remittent, recurrent, relapsed, or metastatic cancers. Post-service review may be required through Carelon.

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81177	ATN1 (atrophin 1) (eg, dentatorubral-pallidoluysian atrophy) gene analysis, evaluation to detect abnormal (eg, expanded) alleles	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
81178	ATXN1 (ataxin 1) (eg, spinocerebellar ataxia) gene analysis, evaluation to detect abnormal (eg, expanded) alleles	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
81179	ATXN2 (ataxin 2) (eg, spinocerebellar ataxia) gene analysis, evaluation to detect abnormal (eg, expanded) alleles	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
81180	ATXN3 (ataxin 3) (eg, spinocerebellar ataxia, Machado-Joseph disease) gene analysis, evaluation to detect abnormal (eg, expanded) alleles	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
81181	ATXN7 (ataxin 7) (eg, spinocerebellar ataxia) gene analysis, evaluation to detect abnormal (eg, expanded) alleles	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
81182	ATXN8OS (ATXN8 opposite strand [non-protein coding]) (eg, spinocerebellar ataxia) gene analysis, evaluation to detect abnormal (eg, expanded) alleles	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.

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81183	ATXN10 (ataxin 10) (eg, spinocerebellar ataxia) gene analysis, evaluation to detect abnormal (eg, expanded) alleles	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
81184	CACNA1A (calcium voltage-gated channel subunit alpha1 A) (eg, spinocerebellar ataxia) gene analysis; evaluation to detect abnormal (eg, expanded) alleles	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
81185	CACNA1A (calcium voltage-gated channel subunit alpha1 A) (eg, spinocerebellar ataxia) gene analysis; full gene sequence	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
81186	CACNA1A (calcium voltage-gated channel subunit alpha1 A) (eg, spinocerebellar ataxia) gene analysis; known familial variant	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
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 Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
81188	CSTB (cystatin B) (eg, Unverricht-Lundborg disease) gene analysis; evaluation to detect abnormal (eg, expanded) alleles	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.

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81189	CSTB (cystatin B) (eg, Unverricht-Lundborg disease) gene analysis; full gene sequence	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
81190	CSTB (cystatin B) (eg, Unverricht-Lundborg disease) gene analysis; known familial variant(s)	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
81191	NTRK1 (neurotrophic receptor tyrosine kinase 1) (eg, solid tumors) translocation analysis	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. WA PLAN MEMBERS ONLY: No prior authorization required for requests related to stage 3 or 4 cancer; or remittent, recurrent, relapsed, or metastatic cancers. Post-service review may be required through Carelon.
81192	NTRK2 (neurotrophic receptor tyrosine kinase 2) (eg, solid tumors) translocation analysis	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. WA PLAN MEMBERS ONLY: No prior authorization required for requests related to stage 3 or 4 cancer; or remittent, recurrent, relapsed, or metastatic cancers. Post-service review may be required through Carelon.

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81193	NTRK3 (neurotrophic receptor tyrosine kinase 3) (eg, solid tumors) translocation analysis	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. WA PLAN MEMBERS ONLY: No prior authorization required for requests related to stage 3 or 4 cancer; or remittent, recurrent, relapsed, or metastatic cancers. Post-service review may be required through Carelon.
81194	NTRK (neurotrophic-tropomyosin receptor tyrosine kinase 1, 2, and 3) (eg, solid tumors) translocation analysis	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. WA PLAN MEMBERS ONLY: No prior authorization required for requests related to stage 3 or 4 cancer; or remittent, recurrent, relapsed, or metastatic cancers. Post-service review may be required through Carelon.
81195	Cytogenomic (genome-wide) analysis, hematologic malignancy, structural variants and copy number variants, optical genome mapping (OGM)	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
81200	ASPA (aspartoacylase) (eg, Canavan disease) gene analysis, common variants (eg, E285A, Y231X)	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
81201	APC (adenomatous polyposis coli) (eg, familial adenomatosis polyposis [FAP], attenuated FAP) gene analysis; full gene sequence	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
81202	APC (adenomatous polyposis coli) (eg, familial adenomatosis polyposis [FAP], attenuated FAP) gene analysis; known familial variants	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
81203	APC (adenomatous polyposis coli) (eg, familial adenomatosis polyposis [FAP], attenuated FAP) gene analysis; duplication/deletion variants	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
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 Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
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 Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
81206	BCR/ABL1 (t(9;22)) (eg, chronic myelogenous leukemia) translocation analysis; major breakpoint, qualitative or quantitative	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. WA PLAN MEMBERS ONLY: No prior authorization required for requests related to stage 3 or 4 cancer; or remittent, recurrent, relapsed, or metastatic cancers. Post-service review may be required through Carelon.

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81207	BCR/ABL1 (t(9;22)) (eg, chronic myelogenous leukemia) translocation analysis; minor breakpoint, qualitative or quantitative	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. WA PLAN MEMBERS ONLY: No prior authorization required for requests related to stage 3 or 4 cancer; or remittent, recurrent, relapsed, or metastatic cancers. Post-service review may be required through Carelon.
81208	BCR/ABL1 (t(9;22)) (eg, chronic myelogenous leukemia) translocation analysis; other breakpoint, qualitative or quantitative	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. WA PLAN MEMBERS ONLY: No prior authorization required for requests related to stage 3 or 4 cancer; or remittent, recurrent, relapsed, or metastatic cancers. Post-service review may be required through Carelon.
81209	BLM (Bloom syndrome, RecQ helicase-like) (eg, Bloom syndrome) gene analysis, 2281del6ins7 variant	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
81210	BRAF (v-raf murine sarcoma viral oncogene homolog B1) (eg, colon cancer), gene analysis, V600E variant	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. WA PLAN MEMBERS ONLY: No prior authorization required for requests related to stage 3 or 4 cancer; or remittent, recurrent, relapsed, or metastatic cancers. Post-service review may be required through Carelon.

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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 Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
81215	BRCA1 (BRCA1, DNA repair associated) (eg, hereditary breast and ovarian cancer) gene analysis; known familial variant	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
81216	BRCA2 (BRCA2, DNA repair associated) (eg, hereditary breast and ovarian cancer) gene analysis; full sequence analysis	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
81217	BRCA2 (BRCA2, DNA repair associated) (eg, hereditary breast and ovarian cancer) gene analysis; known familial variant	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
81218	CEBPA (CCAAT/enhancer binding protein [C/EBP], alpha) (eg, acute myeloid leukemia), gene analysis, full gene sequence	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. WA PLAN MEMBERS ONLY: No prior authorization required for requests related to stage 3 or 4 cancer; or remittent, recurrent, relapsed, or metastatic cancers. Post-service review may be required through Carelon.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
81219	CALR (calreticulin) (eg, myeloproliferative disorders), gene analysis, common variants in exon 9	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. WA PLAN MEMBERS ONLY: No prior authorization required for requests related to stage 3 or 4 cancer; or remittent, recurrent, relapsed, or metastatic cancers. Post-service review may be required through Carelon.
81221	CFTR (cystic fibrosis transmembrane conductance regulator) (eg, cystic fibrosis) gene analysis; known familial variants	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
81222	CFTR (cystic fibrosis transmembrane conductance regulator) (eg, cystic fibrosis) gene analysis; duplication/deletion variants	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
81223	CFTR (cystic fibrosis transmembrane conductance regulator) (eg, cystic fibrosis) gene analysis; full gene sequence	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
81224	CFTR (cystic fibrosis transmembrane conductance regulator) (eg, cystic fibrosis) gene analysis; intron 8 poly-T analysis (eg, male infertility)	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
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 Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.

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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 Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
81227	CYP2C9 (cytochrome P450, family 2, subfamily C, polypeptide 9) (eg, drug metabolism), gene analysis, common variants (eg, *2, *3, *5, *6)	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
81228	Cytogenomic constitutional (genome-wide) microarray analysis; interrogation of genomic regions for copy number variants	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
81229	Cytogenomic constitutional (genome-wide) microarray analysis; interrogation of genomic regions for copy number and single nucleotide polymorphism (SNP) variants for chromosomal abnormalities	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
81230	CYP3A4 (cytochrome P450 family 3 subfamily A member 4) (eg, drug metabolism), gene analysis, common variant(s) (eg, *2, *22)	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
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 Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.

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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 Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
81233	BTK (Bruton's tyrosine kinase) (eg, chronic lymphocytic leukemia) gene analysis, common variants (eg, C481S, C481R, C481F)	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. WA PLAN MEMBERS ONLY: No prior authorization required for requests related to stage 3 or 4 cancer; or remittent, recurrent, relapsed, or metastatic cancers. Post-service review may be required through Carelon.
81234	DMPK (DM1 protein kinase) (eg, myotonic dystrophy type 1) gene analysis; evaluation to detect abnormal (expanded) alleles	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
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 Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. WA PLAN MEMBERS ONLY: No prior authorization required for requests related to stage 3 or 4 cancer; or remittent, recurrent, relapsed, or metastatic cancers. Post-service review may be required through Carelon.

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81236	EZH2 (enhancer of zeste 2 polycomb repressive complex 2 subunit) (eg, myelodysplastic syndrome, myeloproliferative neoplasms) gene analysis, full gene sequence	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. WA PLAN MEMBERS ONLY: No prior authorization required for requests related to stage 3 or 4 cancer; or remittent, recurrent, relapsed, or metastatic cancers. Post-service review may be required through Carelon.
81237	EZH2 (enhancer of zeste 2 polycomb repressive complex 2 subunit) (eg, diffuse large B-cell lymphoma) gene analysis, common variant(s) (eg, codon 646)	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. WA PLAN MEMBERS ONLY: No prior authorization required for requests related to stage 3 or 4 cancer; or remittent, recurrent, relapsed, or metastatic cancers. Post-service review may be required through Carelon.
81238	F9 (coagulation factor IX) (eg, hemophilia B), full gene sequence	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
81239	DMPK (DM1 protein kinase) (eg, myotonic dystrophy type 1) gene analysis; characterization of alleles (eg, expanded size)	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
81240	F2 (prothrombin, coagulation factor II) (eg, hereditary hypercoagulability) gene analysis, 20210G>A variant	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.

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81241	F5 (coagulation factor V) (eg, hereditary hypercoagulability) gene analysis, Leiden variant	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
81242	FANCC (Fanconi anemia, complementation group C) (eg, Fanconi anemia, type C) gene analysis, common variant (eg, IVS4+4A>T)	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
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 Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
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 Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
81245	FLT3 (fms-related tyrosine kinase 3) (eg, acute myeloid leukemia), gene analysis; internal tandem duplication (ITD) variants (ie, exons 14, 15)	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. WA PLAN MEMBERS ONLY: No prior authorization required for requests related to stage 3 or 4 cancer; or remittent, recurrent, relapsed, or metastatic cancers. Post-service review may be required through Carelon.

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81246	FLT3 (fms-related tyrosine kinase 3) (eg, acute myeloid leukemia), gene analysis; tyrosine kinase domain (TKD) variants (eg, D835, I836)	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. WA PLAN MEMBERS ONLY: No prior authorization required for requests related to stage 3 or 4 cancer; or remittent, recurrent, relapsed, or metastatic cancers. Post-service review may be required through Carelon.
81247	G6PD (glucose-6-phosphate dehydrogenase) (eg, hemolytic anemia, jaundice), gene analysis; common variant(s) (eg, A, A-)	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
81248	G6PD (glucose-6-phosphate dehydrogenase) (eg, hemolytic anemia, jaundice), gene analysis; known familial variant(s)	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
81249	G6PD (glucose-6-phosphate dehydrogenase) (eg, hemolytic anemia, jaundice), gene analysis; full gene sequence	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
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 Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
81251	GBA (glucosidase, beta, acid) (eg, Gaucher disease) gene analysis, common variants (eg, N370S, 84GG, L444P, IVS2+1G>A)	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.

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81252	GJB2 (gap junction protein, beta 2, 26kDa, connexin 26) (eg, nonsyndromic hearing loss) gene analysis; full gene sequence	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
81253	GJB2 (gap junction protein, beta 2, 26kDa, connexin 26) (eg, nonsyndromic hearing loss) gene analysis; known familial variants	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
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 Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
81255	HEXA (hexosaminidase A [alpha polypeptide]) (e.g., Tay-Sachs disease) gene analysis, common variants (e.g., 1278insTATC, 1421+1G>C, G269S)	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
81256	HFE (hemochromatosis) (eg, hereditary hemochromatosis) gene analysis, common variants (eg, C282Y, H63D)	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
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 Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.

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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 Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
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 Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
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 Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. WA PLAN MEMBERS ONLY: No prior authorization required for requests related to stage 3 or 4 cancer; or remittent, recurrent, relapsed, or metastatic cancers. Post-service review may be required through Carelon.
81262	IGH@ (Immunoglobulin heavy chain locus) (eg, leukemias and lymphomas, B-cell), gene rearrangement analysis to detect abnormal clonal population(s); direct probe methodology (eg, Southern blot)	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. WA PLAN MEMBERS ONLY: No prior authorization required for requests related to stage 3 or 4 cancer; or remittent, recurrent, relapsed, or metastatic cancers. Post-service review may be required through Carelon.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
81263	IGH@ (Immunoglobulin heavy chain locus) (eg, leukemia and lymphoma, B-cell), variable region somatic mutation analysis	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. WA PLAN MEMBERS ONLY: No prior authorization required for requests related to stage 3 or 4 cancer; or remittent, recurrent, relapsed, or metastatic cancers. Post-service review may be required through Carelon.
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 Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. WA PLAN MEMBERS ONLY: No prior authorization required for requests related to stage 3 or 4 cancer; or remittent, recurrent, relapsed, or metastatic cancers. Post-service review may be required through Carelon.
81265	Comparative analysis using Short Tandem Repeat (STR) markers; patient and comparative specimen (eg, pre-transplant recipient and donor germline testing, post-transplant non-hematopoietic recipient germlin	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. WA PLAN MEMBERS ONLY: No prior authorization required for requests related to stage 3 or 4 cancer; or remittent, recurrent, relapsed, or metastatic cancers. Post-service review may be required through Carelon.
81266	Comparative analysis using Short Tandem Repeat (STR) markers; each additional specimen (eg, additional cord blood donor, additional fetal samples from different cultures, or additional zygosity in multiple birth pregnancies	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.

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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 Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
81270	JAK2 (Janus kinase 2) (eg, myeloproliferative disorder) gene analysis, p.Val617Phe (V617F) variant	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. WA PLAN MEMBERS ONLY: No prior authorization required for requests related to stage 3 or 4 cancer; or remittent, recurrent, relapsed, or metastatic cancers. Post-service review may be required through Carelon.
81271	HTT (huntingtin) (eg, Huntington disease) gene analysis; evaluation to detect abnormal (eg, expanded) alleles	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
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 Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. WA PLAN MEMBERS ONLY: No prior authorization required for requests related to stage 3 or 4 cancer; or remittent, recurrent, relapsed, or metastatic cancers. Post-service review may be required through Carelon.

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81273	KIT (v-kit Hardy-Zuckerman 4 feline sarcoma viral oncogene homolog) (eg, mastocytosis), gene analysis, D816 variant(s)	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. WA PLAN MEMBERS ONLY: No prior authorization required for requests related to stage 3 or 4 cancer; or remittent, recurrent, relapsed, or metastatic cancers. Post-service review may be required through Carelon.
81274	HTT (huntingtin) (eg, Huntington disease) gene analysis; characterization of alleles (eg, expanded size)	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
81275	KRAS (Kirsten rat sarcoma viral oncogene homolog) (eg, carcinoma) gene analysis; variants in exon 2 (eg, codons 12 and 13)	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. WA PLAN MEMBERS ONLY: No prior authorization required for requests related to stage 3 or 4 cancer; or remittent, recurrent, relapsed, or metastatic cancers. Post-service review may be required through Carelon.
81276	KRAS (Kirsten rat sarcoma viral oncogene homolog) (eg, carcinoma) gene analysis; additional variant(s) (eg, codon 61, codon 146)	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. WA PLAN MEMBERS ONLY: No prior authorization required for requests related to stage 3 or 4 cancer; or remittent, recurrent, relapsed, or metastatic cancers. Post-service review may be required through Carelon.

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81277	Cytogenomic neoplasia (genome-wide) microarray analysis, interrogation of genomic regions for copy number and loss-of-heterozygosity variants for chromosomal abnormalities	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
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 Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. WA PLAN MEMBERS ONLY: No prior authorization required for requests related to stage 3 or 4 cancer; or remittent, recurrent, relapsed, or metastatic cancers. Post-service review may be required through Carelon.
81279	JAK2 (Janus kinase 2) (eg, myeloproliferative disorder) targeted sequence analysis (eg, exons 12 and 13)	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. WA PLAN MEMBERS ONLY: No prior authorization required for requests related to stage 3 or 4 cancer; or remittent, recurrent, relapsed, or metastatic cancers. Post-service review may be required through Carelon.
81283	IFNL3 (interferon, lambda 3) (eg, drug response), gene analysis, rs12979860 variant	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
81284	FXN (frataxin) (eg, Friedreich ataxia) gene analysis; evaluation to detect abnormal (expanded) alleles	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.

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81285	FXN (frataxin) (eg, Friedreich ataxia) gene analysis; characterization of alleles (eg, expanded size)	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
81286	FXN (frataxin) (eg, Friedreich ataxia) gene analysis; full gene sequence	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
81287	MGMT (o-6-methylguanine-dna methyltransferase) (eg, glioblastoma multiforme) promoter methylation analysis	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. WA PLAN MEMBERS ONLY: No prior authorization required for requests related to stage 3 or 4 cancer; or remittent, recurrent, relapsed, or metastatic cancers. Post-service review may be required through Carelon.
81289	FXN (frataxin) (eg, Friedreich ataxia) gene analysis; known familial variant(s)	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
81290	MCOLN1 (mucolipin 1) (eg, Mucolipidosis, type IV) gene analysis, common variants (eg, IVS3-2A>G, del6.4kb)	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
81291	MTHFR (5,10-methylenetetrahydrofolate reductase) (eg, hereditary hypercoagulability) gene analysis, common variants (eg, 677T, 1298C)	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.

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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 Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
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 Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
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 Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
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 Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
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 Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
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 Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.

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81298	MSH6 (mutS homolog 6 [E. coli]) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; full sequence analysis	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
81299	MSH6 (mutS homolog 6 [E. coli]) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; known familial variants	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
81300	MSH6 (mutS homolog 6 [E. coli]) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; duplication/deletion variants	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
81302	MECP2 (methyl CpG binding protein 2) (eg, Rett syndrome) gene analysis; full sequence analysis	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
81303	MECP2 (methyl CpG binding protein 2) (eg, Rett syndrome) gene analysis; known familial variant	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
81304	MECP2 (methyl CpG binding protein 2) (eg, Rett syndrome) gene analysis; duplication/deletion variants	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.

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81305	MYD88 (myeloid differentiation primary response 88) (eg, Waldenstrom's macroglobulinemia, lymphoplasmacytic leukemia) gene analysis, p.Leu265Pro (L265P) variant	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. WA PLAN MEMBERS ONLY: No prior authorization required for requests related to stage 3 or 4 cancer; or remittent, recurrent, relapsed, or metastatic cancers. Post-service review may be required through Carelon.
81306	NUDT15 (nudix hydrolase 15) (eg, drug metabolism) gene analysis, common variant(s) (eg, *2, *3, *4, *5, *6)	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
81307	PALB2 (partner and localizer of BRCA2) (EG, breast and pancreatic cancer) gene analysis; full gene sequence	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. WA PLAN MEMBERS ONLY: No prior authorization required for requests related to stage 3 or 4 cancer; or remittent, recurrent, relapsed, or metastatic cancers. Post-service review may be required through Carelon.
81308	PALB2 (partner and localizer of BRCA2) (EG, breast and pancreatic cancer) gene analysis; known familial variant	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.

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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 Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. WA PLAN MEMBERS ONLY: No prior authorization required for requests related to stage 3 or 4 cancer; or remittent, recurrent, relapsed, or metastatic cancers. Post-service review may be required through Carelon.
81310	NPM1 (nucleophosmin) (eg, acute myeloid leukemia) gene analysis, exon 12 variants	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. WA PLAN MEMBERS ONLY: No prior authorization required for requests related to stage 3 or 4 cancer; or remittent, recurrent, relapsed, or metastatic cancers. Post-service review may be required through Carelon.
81311	NRAS (neuroblastoma RAS viral [v-ras] oncogene homolog) (eg, colorectal carcinoma), gene analysis, variants in exon 2 (eg, codons 12 and 13) and exon 3 (eg, codon 61)	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. WA PLAN MEMBERS ONLY: No prior authorization required for requests related to stage 3 or 4 cancer; or remittent, recurrent, relapsed, or metastatic cancers. Post-service review may be required through Carelon.
81312	PABPN1 (poly[A] binding protein nuclear 1) (eg, oculopharyngeal muscular dystrophy) gene analysis, evaluation to detect abnormal (eg, expanded) alleles	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.

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81313	PCA3/KLK3 (prostate cancer antigen 3 [non-protein coding]/kallikrein-related peptidase 3 [prostate specific antigen]) ratio (eg, prostate cancer)	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. WA PLAN MEMBERS ONLY: No prior authorization required for requests related to stage 3 or 4 cancer; or remittent, recurrent, relapsed, or metastatic cancers. Post-service review may be required through Carelon.
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 Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. WA PLAN MEMBERS ONLY: No prior authorization required for requests related to stage 3 or 4 cancer; or remittent, recurrent, relapsed, or metastatic cancers. Post-service review may be required through Carelon.
81315	PML/RARalpha, (t(15;17)), (promyelocytic leukemia/retinoic acid receptor alpha) (eg, promyelocytic leukemia) translocation analysis; common breakpoints (eg, intron 3 and intron 6), qualitative or quantitative	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. WA PLAN MEMBERS ONLY: No prior authorization required for requests related to stage 3 or 4 cancer; or remittent, recurrent, relapsed, or metastatic cancers. Post-service review may be required through Carelon.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
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 Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. WA PLAN MEMBERS ONLY: No prior authorization required for requests related to stage 3 or 4 cancer; or remittent, recurrent, relapsed, or metastatic cancers. Post-service review may be required through Carelon.
81317	PMS2 (postmeiotic segregation increased 2 [S. cerevisiae]) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; full sequence analysis	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
81318	PMS2 (postmeiotic segregation increased 2 [S. cerevisiae]) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; known familial variants	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
81319	PMS2 (postmeiotic segregation increased 2 [S. cerevisiae]) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; duplication/deletion variants	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
81320	PLCG2 (phospholipase C gamma 2) (eg, chronic lymphocytic leukemia) gene analysis, common variants (eg, R665W, S707F, L845F)	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. WA PLAN MEMBERS ONLY: No prior authorization required for requests related to stage 3 or 4 cancer; or remittent, recurrent, relapsed, or metastatic cancers. Post-service review may be required through Carelon.

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81321	PTEN (phosphatase and tensin homolog) (eg, Cowden syndrome, PTEN hamartoma tumor syndrome) gene analysis; full sequence analysis	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. WA PLAN MEMBERS ONLY: No prior authorization required for requests related to stage 3 or 4 cancer; or remittent, recurrent, relapsed, or metastatic cancers. Post-service review may be required through Carelon.
81322	PTEN (phosphatase and tensin homolog) (eg, Cowden syndrome, PTEN hamartoma tumor syndrome) gene analysis; known familial variant	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
81323	PTEN (phosphatase and tensin homolog) (eg, Cowden syndrome, PTEN hamartoma tumor syndrome) gene analysis; duplication/deletion variant	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. WA PLAN MEMBERS ONLY: No prior authorization required for requests related to stage 3 or 4 cancer; or remittent, recurrent, relapsed, or metastatic cancers. Post-service review may be required through Carelon.
81324	PMP22 (peripheral myelin protein 22) (eg, Charcot-Marie-Tooth, hereditary neuropathy with liability to pressure palsies) gene analysis; duplication/deletion analysis	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
81325	PMP22 (peripheral myelin protein 22) (eg, Charcot-Marie-Tooth, hereditary neuropathy with liability to pressure palsies) gene analysis; full sequence analysis	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.

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81326	PMP22 (peripheral myelin protein 22) (eg, Charcot-Marie-Tooth, hereditary neuropathy with liability to pressure palsies) gene analysis; known familial variant	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
81327	SEPT9 (Septin9) (eg, colorectal cancer) promoter methylation analysis	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. WA PLAN MEMBERS ONLY: No prior authorization required for requests related to stage 3 or 4 cancer; or remittent, recurrent, relapsed, or metastatic cancers. Post-service review may be required through Carelon.
81328	SLCO1B1 (solute carrier organic anion transporter family, member 1B1) (eg, adverse drug reaction), gene analysis, common variant(s) (eg, *5)	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
81330	SMPD1(sphingomyelin phosphodiesterase 1, acid lysosomal) (eg, Niemann-Pick disease, Type A) gene analysis, common variants (eg, R496L, L302P, fsP330)	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
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 Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
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 Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.

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81333	TGFBI (transforming growth factor beta-induced) (eg, corneal dystrophy) gene analysis, common variants (eg, R124H, R124C, R124L, R555W, R555Q)	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
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 Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
81335	TPMT (thiopurine S-methyltransferase) (eg, drug metabolism), gene analysis, common variants (eg, *2, *3)	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
81336	SMN1 (survival of motor neuron 1, telomeric) (eg, spinal muscular atrophy) gene analysis; full gene sequence	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
81337	SMN1 (survival of motor neuron 1, telomeric) (eg, spinal muscular atrophy) gene analysis; known familial sequence variant(s)	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
81338	MPL (MPL proto-oncogene, thrombopoietin receptor) (eg, myeloproliferative disorder) gene analysis; common variants (eg, W515A, W515K, W515L, W515R)	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. WA PLAN MEMBERS ONLY: No prior authorization required for requests related to stage 3 or 4 cancer; or remittent, recurrent, relapsed, or metastatic cancers. Post-service review may be required through Carelon.
81339	MPL (MPL proto-oncogene, thrombopoietin receptor) (eg, myeloproliferative disorder) gene analysis; sequence analysis, exon 10	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. WA PLAN MEMBERS ONLY: No prior authorization required for requests related to stage 3 or 4 cancer; or remittent, recurrent, relapsed, or metastatic cancers. Post-service review may be required through Carelon.
81340	TRB@ (T cell antigen receptor, beta) (eg, leukemia and lymphoma), gene rearrangement analysis to detect abnormal clonal population(s); using amplification methodology (eg, polymerase chain reaction)	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. WA PLAN MEMBERS ONLY: No prior authorization required for requests related to stage 3 or 4 cancer; or remittent, recurrent, relapsed, or metastatic cancers. Post-service review may be required through Carelon.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
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 Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. WA PLAN MEMBERS ONLY: No prior authorization required for requests related to stage 3 or 4 cancer; or remittent, recurrent, relapsed, or metastatic cancers. Post-service review may be required through Carelon.
81342	TRG@ (T cell antigen receptor, gamma) (eg, leukemia and lymphoma), gene rearrangement analysis, evaluation to detect abnormal clonal population(s)	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. WA PLAN MEMBERS ONLY: No prior authorization required for requests related to stage 3 or 4 cancer; or remittent, recurrent, relapsed, or metastatic cancers. Post-service review may be required through Carelon.
81343	PPP2R2B (protein phosphatase 2 regulatory subunit Bbeta) (eg, spinocerebellar ataxia) gene analysis, evaluation to detect abnormal (eg, expanded) alleles	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
81344	TBP (TATA box binding protein) (eg, spinocerebellar ataxia) gene analysis, evaluation to detect abnormal (eg, expanded) alleles	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
81345	TERT (telomerase reverse transcriptase) (eg, thyroid carcinoma, glioblastoma multiforme) gene analysis, targeted sequence analysis (eg, promoter region)	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. WA PLAN MEMBERS ONLY: No prior authorization required for requests related to stage 3 or 4 cancer; or remittent, recurrent, relapsed, or metastatic cancers. Post-service review may be required through Carelon.
81346	TYMS (thymidylate synthetase) (eg, 5-fluorouracil/5-FU drug metabolism), gene analysis, common variant(s) (eg, tandem repeat variant)	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
81347	SF3B1 (splicing factor [3b] subunit B1) (eg, myelodysplastic syndrome/acute myeloid leukemia) gene analysis, common variants (eg, A672T, E622D, L833F, R625C, R625L)	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. WA PLAN MEMBERS ONLY: No prior authorization required for requests related to stage 3 or 4 cancer; or remittent, recurrent, relapsed, or metastatic cancers. Post-service review may be required through Carelon.
81348	SRSF2 (serine and arginine-rich splicing factor 2) (eg, myelodysplastic syndrome, acute myeloid leukemia) gene analysis, common variants (eg, P95H, P95L)	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. WA PLAN MEMBERS ONLY: No prior authorization required for requests related to stage 3 or 4 cancer; or remittent, recurrent, relapsed, or metastatic cancers. Post-service review may be required through Carelon.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
81349	Cytogenomic (genome-wide) analysis for constitutional chromosomal abnormalities; interrogation of genomic regions for copy number and loss-of-heterozygosity variants, low-pass sequencing analysis	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
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 Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
81351	TP53 (tumor protein 53) (eg, Li-Fraumeni syndrome) gene analysis; full gene sequence	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. WA PLAN MEMBERS ONLY: No prior authorization required for requests related to stage 3 or 4 cancer; or remittent, recurrent, relapsed, or metastatic cancers. Post-service review may be required through Carelon.
81352	TP53 (tumor protein 53) (eg, Li-Fraumeni syndrome) gene analysis; targeted sequence analysis (eg, 4 oncology)	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. WA PLAN MEMBERS ONLY: No prior authorization required for requests related to stage 3 or 4 cancer; or remittent, recurrent, relapsed, or metastatic cancers. Post-service review may be required through Carelon.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
81353	TP53 (tumor protein 53) (eg, Li-Fraumeni syndrome) gene analysis; known familial variant	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. WA PLAN MEMBERS ONLY: No prior authorization required for requests related to stage 3 or 4 cancer; or remittent, recurrent, relapsed, or metastatic cancers. Post-service review may be required through Carelon.
81355	VKORC1 (vitamin K epoxide reductase complex, subunit 1) (e.g., warfarin metabolism), gene analysis, common variants (e.g., -1639/3673)*	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
81357	U2AF1 (U2 small nuclear RNA auxiliary factor 1) (eg, myelodysplastic syndrome, acute myeloid leukemia) gene analysis, common variants (eg, S34F, S34Y, Q157R, Q157P)	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. WA PLAN MEMBERS ONLY: No prior authorization required for requests related to stage 3 or 4 cancer; or remittent, recurrent, relapsed, or metastatic cancers. Post-service review may be required through Carelon.
81360	ZRSR2 (zinc finger CCCH-type, RNA binding motif and serine/arginine-rich 2) (eg, myelodysplastic syndrome, acute myeloid leukemia) gene analysis, common variant(s) (eg, E65fs, E122fs, R448fs)	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. WA PLAN MEMBERS ONLY: No prior authorization required for requests related to stage 3 or 4 cancer; or remittent, recurrent, relapsed, or metastatic cancers. Post-service review may be required through Carelon.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
81362	HBB (hemoglobin, subunit beta) (eg, sickle cell anemia, beta thalassemia, hemoglobinopathy); known familial variant(s)	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
81363	HBB (hemoglobin, subunit beta) (eg, sickle cell anemia, beta thalassemia, hemoglobinopathy); duplication/deletion variant(s)	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
81364	HBB (hemoglobin, subunit beta) (eg, sickle cell anemia, beta thalassemia, hemoglobinopathy); full gene sequence	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
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)	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
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	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
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])	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. WA PLAN MEMBERS ONLY: No prior authorization required for requests related to stage 3 or 4 cancer; or remittent, recurrent, relapsed, or metastatic cancers. Post-service review may be required through Carelon.
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)	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. WA PLAN MEMBERS ONLY: No prior authorization required for requests related to stage 3 or 4 cancer; or remittent, recurrent, relapsed, or metastatic cancers. Post-service review may be required through Carelon.
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	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. WA PLAN MEMBERS ONLY: No prior authorization required for requests related to stage 3 or 4 cancer; or remittent, recurrent, relapsed, or metastatic cancers. Post-service review may be required through Carelon.
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)	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.

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81406	Molecular pathology procedure, Level 7 (eg, analysis of 11-25 exons by DNA sequence analysis, mutation scanning or duplication/deletion variants of 26-50 exons, cytogenomic array analysis for neoplasia)	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
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)	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
81408	Molecular pathology procedure, Level 9 (eg, analysis of >50 exons in a single gene by DNA sequence analysis)	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. WA PLAN MEMBERS ONLY: No prior authorization required for requests related to stage 3 or 4 cancer; or remittent, recurrent, relapsed, or metastatic cancers. Post-service review may be required through Carelon.
81410	Aortic dysfunction or dilation (eg, Marfan syndrome, Loeys Dietz syndrome, Ehler Danlos syndrome type IV, arterial tortuosity syndrome); genomic sequence analysis panel, must include sequencing of at least 9 genes, including FBN1, TGFBR1, TGFBR2, COL3A1, MYH11, ACTA2, SLC2A10, SMAD3, and MYLK	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.

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81411	Aortic dysfunction or dilation (eg, Marfan syndrome, Loeys Dietz syndrome, Ehler Danlos syndrome type IV, arterial tortuosity syndrome); duplication/deletion analysis panel, must include analyses for TGFBR1, TGFBR2, MYH11, and COL3A1	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
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 Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
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 Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
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 Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.

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81415	Exome (eg, unexplained constitutional or heritable disorder or syndrome); sequence analysis	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
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 Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
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 Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
81418	Drug metabolism (eg, pharmacogenomics) genomic sequence analysis panel, must include testing of at least 6 genes, including CYP2C19, CYP2D6, and CYP2D6 duplication/deletion analysis	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
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 Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.

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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 Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
81425	Genome (eg, unexplained constitutional or heritable disorder or syndrome); sequence analysis	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
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 Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
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 Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
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 Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.

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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 Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
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 14 genes, including ATM, BRCA1, BRCA2, BRIP1, CDH1, MLH1, MSH2, MSH6, NBN, PALB2, PTEN, RAD51C, STK11, and TP53	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. WA PLAN MEMBERS ONLY: No prior authorization required for requests related to stage 3 or 4 cancer; or remittent, recurrent, relapsed, or metastatic cancers. Post-service review may be required through Carelon.
81434	Hereditary retinal disorders (eg, retinitis pigmentosa, Leber congenital amaurosis, cone-rod dystrophy), genomic sequence analysis panel, must include sequencing of at least 15 genes, including ABCA4, CNGA1, CRB1, EYS, PDE6A, PDE6B, PRPF31, PRPH2, RDH12, RHO, RP1, RP2, RPE65, RPGR, and USH2A	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
81435	Hereditary colon cancer syndromes (eg, Lynch syndrome, familial adenomatosis polyposis); genomic sequence analysis panel, must include analysis of at least 7 genes, including APC, CHEK2, MLH1, MSH2, MSH6, MUTYH, and PMS2	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. WA PLAN MEMBERS ONLY: No prior authorization required for requests related to stage 3 or 4 cancer; or remittent, recurrent, relapsed, or metastatic cancers. Post-service review may be required through Carelon.

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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 Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. WA PLAN MEMBERS ONLY: No prior authorization required for requests related to stage 3 or 4 cancer; or remittent, recurrent, relapsed, or metastatic cancers. Post-service review may be required through Carelon.
81439	Inherited cardiomyopathy (eg, hypertrophic cardiomyopathy, dilated cardiomyopathy, arrhythmogenic right ventricular cardiomyopathy) genomic sequence analysis panel, must include sequencing of at least 5 genes, including DSG2, MYBPC3, MYH7, PKP2, and TTN	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
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 Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.

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81441	Inherited bone marrow failure syndromes (IBMFS) (eg, Fanconi anemia, dyskeratosis congenita, Diamond-Blackfan anemia, Shwachman-Diamond syndrome, GATA2 deficiency syndrome, congenital amegakaryocytic thrombocytopenia) sequence analysis panel, must include sequencing of at least 30 genes, including BRCA2..	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
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 Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
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 Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.

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81445	Solid organ neoplasm, genomic sequence analysis panel, 5-50 genes (eg, ALK, BRAF, CDKN2A, EGFR, ERBB2, KIT, KRAS, MET, NRAS, PDGFRA, PDGFRB, PGR, PIK3CA, PTEN, RET), interrogation for sequence variants and copy number variants or rearrangements, if performed; DNA analysis or combined DNA and RNA analysis	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. WA PLAN MEMBERS ONLY: No prior authorization required for requests related to stage 3 or 4 cancer; or remittent, recurrent, relapsed, or metastatic cancers. Post-service review may be required through Carelon.
81448	Hereditary peripheral neuropathies (eg, Charcot-Marie-Tooth, spastic paraplegia), genomic sequence analysis panel, must include sequencing of at least 5 peripheral neuropathy-related genes (eg, BSCL2, GJB1, MFN2, MPZ, REEP1, SPAST, SPG11, SPTLC1)	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
81449	Solid organ neoplasm, genomic sequence analysis panel, 5-50 genes (eg, ALK, BRAF, CDKN2A, EGFR, ERBB2, KIT, KRAS, MET, NRAS, PDGFRA, PDGFRB, PGR, PIK3CA, PTEN, RET), interrogation for sequence variants and copy number variants or rearrangements, if performed; RNA analysis	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. WA PLAN MEMBERS ONLY: No prior authorization required for requests related to stage 3 or 4 cancer; or remittent, recurrent, relapsed, or metastatic cancers. Post-service review may be required through Carelon.

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81450	Hematolymphoid neoplasm or disorder, genomic sequence analysis panel, 5-50 genes (eg, BRAF, CEBPA, DNMT3A, EZH2, FLT3, IDH1, IDH2, JAK2, KIT, KRAS, MLL, NOTCH1, NPM1, NRAS), 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 Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. WA PLAN MEMBERS ONLY: No prior authorization required for requests related to stage 3 or 4 cancer; or remittent, recurrent, relapsed, or metastatic cancers. Post-service review may be required through Carelon.
81451	Hematolymphoid neoplasm or disorder, genomic sequence analysis panel, 5-50 genes (eg, BRAF, CEBPA, DNMT3A, EZH2, FLT3, IDH1, IDH2, JAK2, KIT, KRAS, MLL, NOTCH1, NPM1, NRAS), interrogation for sequence variants, and copy number variants or rearrangements, or isoform expression or mRNA expression levels, if performed; RNA analysis	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. WA PLAN MEMBERS ONLY: No prior authorization required for requests related to stage 3 or 4 cancer; or remittent, recurrent, relapsed, or metastatic cancers. Post-service review may be required through Carelon.
81455	Solid organ or hematolymphoid neoplasm or disorder, 51 or greater genes, genomic sequence analysis panel, interrogation for sequence variants and copy number variants or rearrangements, or isoform expression or mRNA expression levels, if performed; DNA analysis or combined DNA and RNA analysis	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. WA PLAN MEMBERS ONLY: No prior authorization required for requests related to stage 3 or 4 cancer; or remittent, recurrent, relapsed, or metastatic cancers. Post-service review may be required through Carelon.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
81456	Solid organ or hematolymphoid neoplasm or disorder, 51 or greater genes, genomic sequence analysis panel, interrogation for sequence variants and copy number variants or rearrangements, or isoform expression or mRNA expression levels, if performed; RNA analysis	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. WA PLAN MEMBERS ONLY: No prior authorization required for requests related to stage 3 or 4 cancer; or remittent, recurrent, relapsed, or metastatic cancers. Post-service review may be required through Carelon.
81457	Solid organ neoplasm, genomic sequence analysis panel, interrogation for sequence variants, DNA analysis, microsatellite instability	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
81458	Solid organ neoplasm, genomic sequence analysis panel, interrogation for sequence variants; DNA analysis, copy number variants and microsatellite instability	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
81459	Solid organ neoplasm, genomic sequence analysis panel, interrogation for sequence variants; DNA analysis or combined DNA & RNA analysis, copy number variants, microsatellite instability	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
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 Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
81462	Solid organ neoplasm, genomic sequence analysis panel, cell-free nucleic acid, interrogation for sequence variants; DNA analysis or combined DNA & RNA analysis. copy number variants	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
81463	Solid organ neoplasm, genomic sequence analysis panel, cell-free nucleic acid, interrogation for sequence variants; DNA analysis, copy number variants & microsatellite instability	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
81464	Solid organ neoplasm, genomic sequence analysis panel, cell-free nucleic acid, interrogation for sequence variants; DNA analysis or combined DNA & RNA analysis, copy number variants	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
81465	Whole mitochondrial genome large deletion analysis panel (eg, Kearns-Sayre syndrome, chronic progressive external ophthalmoplegia), including heteroplasmy detection, if performed	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
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 Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
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 Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
81479	Unlisted molecular pathology procedure	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. WA PLAN MEMBERS ONLY: No prior authorization required for requests related to stage 3 or 4 cancer; or remittent, recurrent, relapsed, or metastatic cancers. Post-service review may be required through Carelon.
81490	Autoimmune (rheumatoid arthritis), analysis of 12 biomarkers using immunoassays, utilizing serum, prognostic algorithm reported as a disease activity score	Possible Denial; Medical Records Optional	Investigative	Documentation optional.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
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 Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
81500	Oncology (ovarian), biochemical assays of two proteins (CA-125 and HE4), utilizing serum, with menopausal status, algorithm reported as a risk score	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
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	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
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 Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. WA PLAN MEMBERS ONLY: No prior authorization required for requests related to stage 3 or 4 cancer; or remittent, recurrent, relapsed, or metastatic cancers. Post-service review may be required through Carelon.

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81515	Infectious disease, bacterial vaginosis and vaginitis, real-time PCR amplification of DNA markers for Atopobium vaginae, Atopobium species, Megasphaera type 1, and Bacterial Vaginosis Associated Bacteria-2 (BVAB-2), utilizing vaginal-fluid specimens, algorithm reported as positive or negative for high likelihood of bacterial vaginosis, includes separate detection of Trichomonas vaginalis and Candida species (C. albicans, C. tropicalis, C. parapsilosis, C. dubliniensis), Candida glabrata/Candida krusei, when reported	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
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 Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. WA PLAN MEMBERS ONLY: No prior authorization required for requests related to stage 3 or 4 cancer; or remittent, recurrent, relapsed, or metastatic cancers. Post-service review may be required through Carelon.
81519	Oncology (breast), mRNA, gene expression profiling by real-time RT-PCR of 21 genes, utilizing formalin-fixed paraffin embedded tissue, algorithm reported as recurrence score	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. WA PLAN MEMBERS ONLY: No prior authorization required for requests related to stage 3 or 4 cancer; or remittent, recurrent, relapsed, or metastatic cancers. Post-service review may be required through Carelon.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
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 Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
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 Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. WA PLAN MEMBERS ONLY: No prior authorization required for requests related to stage 3 or 4 cancer; or remittent, recurrent, relapsed, or metastatic cancers. Post-service review may be required through Carelon.
81522	Oncology (breast), MRNA, gene expression profiling by RT-PCR OF 12 genes (8 content and 4 housekeeping), utilizing formalin-fixed paraffin-embedded tissue, algorithm reported as recurrence risk score	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. WA PLAN MEMBERS ONLY: No prior authorization required for requests related to stage 3 or 4 cancer; or remittent, recurrent, relapsed, or metastatic cancers. Post-service review may be required through Carelon.
81523	Oncology (breast), mRNA, next-generation sequencing gene expression profiling of 70 content genes and 31 housekeeping genes, utilizing formalin-fixed paraffin-embedded tissue, algorithm reported as index related to risk to distant metastasis	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. WA PLAN MEMBERS ONLY: No prior authorization required for requests related to stage 3 or 4 cancer; or remittent, recurrent, relapsed, or metastatic cancers. Post-service review may be required through Carelon.

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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 Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. WA PLAN MEMBERS ONLY: No prior authorization required for requests related to stage 3 or 4 cancer; or remittent, recurrent, relapsed, or metastatic cancers. Post-service review may be required through Carelon.
81529	Oncology (cutaneous melanoma), mRNA, gene expression profiling by real-time RT-PCR of 31 genes (28 content and 3 housekeeping), utilizing formalin-fixed paraffin-embedded tissue, algorithm reported as recurrence risk, including likelihood of sentinel lymph node metastasis	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. WA PLAN MEMBERS ONLY: No prior authorization required for requests related to stage 3 or 4 cancer; or remittent, recurrent, relapsed, or metastatic cancers. Post-service review may be required through Carelon.
81538	Oncology (lung), mass spectrometric 8-protein signature, including amyloid A, utilizing serum, prognostic and predictive algorithm reported as good versus poor overall survival	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
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	Possible Denial; Medical Records Optional	Investigative	Documentation optional.

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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 Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. WA PLAN MEMBERS ONLY: No prior authorization required for requests related to stage 3 or 4 cancer; or remittent, recurrent, relapsed, or metastatic cancers. Post-service review may be required through Carelon.
81541	Oncology (prostate), mRNA gene expression profiling by real-time RT-PCR of 46 genes (31 content and 15 housekeeping), utilizing formalin-fixed paraffin-embedded tissue, algorithm reported as a disease-specific mortality risk score	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. WA PLAN MEMBERS ONLY: No prior authorization required for requests related to stage 3 or 4 cancer; or remittent, recurrent, relapsed, or metastatic cancers. Post-service review may be required through Carelon.
81542	Oncology (prostate), mRNA, microarray gene expression profiling of 22 content genes, utilizing formalin-fixed paraffin-embedded tissue, algorithm reported as metastasis risk score	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. WA PLAN MEMBERS ONLY: No prior authorization required for requests related to stage 3 or 4 cancer; or remittent, recurrent, relapsed, or metastatic cancers. Post-service review may be required through Carelon.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
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 Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. WA PLAN MEMBERS ONLY: No prior authorization required for requests related to stage 3 or 4 cancer; or remittent, recurrent, relapsed, or metastatic cancers. Post-service review may be required through Carelon.
81551	Oncology (prostate), promoter methylation profiling by real-time PCR of 3 genes (GSTP1, APC, RASSF1), utilizing formalin-fixed paraffin-embedded tissue, algorithm reported as a likelihood of prostate cancer detection on repeat biopsy	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. WA PLAN MEMBERS ONLY: No prior authorization required for requests related to stage 3 or 4 cancer; or remittent, recurrent, relapsed, or metastatic cancers. Post-service review may be required through Carelon.
81552	Oncology (uveal melanoma), MRNA, gene expression profiling by real-time RT-PCR of 15 genes (12 content and 3 housekeeping), utilizing fine needle aspirate or formalin-fixed paraffin-embedded tissue, algorithm reported as risk of metastasis	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. WA PLAN MEMBERS ONLY: No prior authorization required for requests related to stage 3 or 4 cancer; or remittent, recurrent, relapsed, or metastatic cancers. Post-service review may be required through Carelon.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
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 Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
81558	Transplantation medicine (allograft rejection, kidney), mRNA, gene expression profiling by quantitative polymerase chain reaction (qPCR) of 139 genes, utilizing whole blood, algorithm reported as a binary categorization as transplant excellence, which indicates immune quiescence, or not transplant excellence, indicating subclinical rejection	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
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 Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
81599	Unlisted multianalyte assay with algorithmic analysis	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
82233	Beta-amyloid; 1-40 (Abeta 40)	Pre-Service Review Required	Investigative	Submit history and physical, documentation of medical necessity.
82234	Beta-amyloid; 1-42 (Abeta 42)	Pre-Service Review Required	Investigative	Submit history and physical, documentation of medical necessity.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
82306	Vitamin D; 25 hydroxy, includes fraction(s), if performed	Retrospective Review	Medical Necessity	Only covered for diagnoses that are considered medically necessary. Medical records optional. See medical policy 2.04.507
82652	Vitamin D; 1, 25 dihydroxy, includes fraction(s), if performed	Retrospective Review	Medical Necessity	Only covered for diagnoses that are considered medically necessary. Medical records optional. See medical policy 2.04.507
83698	Lipoprotein-associated phospholipase A2 (Lp-PLA2)	Pre-Service Review Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
84393	Tau, phosphorylated (eg, pTau 181, pTau 217), each	Pre-Service Review Required	Investigative	Submit history and physical, documentation of medical necessity.
84394	Tau, total (tTau)	Pre-Service Review Required	Investigative	Submit history and physical, documentation of medical necessity.
84999	Unlisted chemistry procedure	Medical necessity review will be performed upon claims submission with supporting documentation.	Medical Necessity	Upon claims submission Medical necessity review will be performed. When billed with other GT (molecular) codes, submit online review with Carelon at www.providerportal.com. When billed alone or with non-genetic (non-molecular) codes, submit documentation to describe the test, records from related office visit, history and physical.
85999	Unlisted hematology and coagulation procedure	Medical necessity review will be performed upon claims submission with supporting documentation.	Medical Necessity	Review required at claims submission; submit description of procedure with supporting documentation (including operative report if surgical) only for the date of service performed.
86486	Unlisted antigen, skin test, each	Medical necessity review will be performed upon claims submission with supporting documentation.	Medical Necessity	Review required at claims submission; submit description of procedure with supporting documentation (including operative report if surgical) only for the date of service performed.

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86849	Unlisted immunology procedure	Medical necessity review will be performed upon claims submission with supporting documentation.	Medical Necessity	Review required at claims submission; submit description of procedure with supporting documentation (including operative report if surgical) only for the date of service performed.
86910	Blood typing, for paternity testing, per individual; ABO, Rh and MN	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
86911	Blood typing, for paternity testing, per individual; each additional antigen system	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
86999	Unlisted transfusion medicine procedure	Medical necessity review will be performed upon claims submission with supporting documentation.	Medical Necessity	Upon claims submission Medical necessity review will be performed. Submit documentation to describe the services. Include Office Notes from ordering physician related to this study, test or service.
87999	Unlisted microbiology procedure	Medical necessity review will be performed upon claims submission with supporting documentation.	Medical Necessity	Review required at claims submission; submit description of procedure with supporting documentation (including operative report if surgical) only for the date of service performed.
88000	Necropsy (autopsy), gross examination only; without CNS	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
88005	Necropsy (autopsy), gross examination only; with brain	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
88007	Necropsy (autopsy), gross examination only; with brain and spinal cord	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
88012	Necropsy (autopsy), gross examination only; infant with brain	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
88014	Necropsy (autopsy), gross examination only; stillborn or newborn with brain	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
88016	Necropsy (autopsy), gross examination only; macerated stillborn	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.

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88020	Necropsy (autopsy), gross and microscopic; without CNS	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
88025	Necropsy (autopsy), gross and microscopic; with brain	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
88027	Necropsy (autopsy), gross and microscopic; infant with brain	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
88028	Necropsy (autopsy), gross and microscopic; infant with brain	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
88029	Necropsy (autopsy), gross and microscopic; stillborn or newborn with brain	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
88036	Necropsy (autopsy), limited, gross and/or microscopic; regional	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
88037	Necropsy (autopsy), limited, gross and/or microscopic; single organ	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
88040	Necropsy (autopsy); forensic examination	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
88045	Necropsy (autopsy); coroner's call	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
88099	Unlisted necropsy (autopsy) procedure	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
88104	Cytopathology, fluids, washings or brushings, except cervical or vaginal; smears with interpretation	Possible Denial; Medical Records Optional	Investigative	Documentation optional. Reviewed only when 88104, 88305, 88312 & 88361 are billed together with Barrett's Esophagus diagnosis.
88199	Unlisted cytopathology procedure	Medical necessity review will be performed upon claims submission with supporting documentation.	Medical Necessity	Review required at claims submission; submit description of procedure with supporting documentation (including operative report if surgical) only for the date of service performed.

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88299	Unlisted cytogenetic study	Medical necessity review will be performed upon claims submission with supporting documentation.	Medical Necessity	Review required at claims submission; submit description of procedure with supporting documentation (including operative report if surgical) only for the date of service performed.
88305	Level IV - Surgical pathology, gross and microscopic examination Abortion - spontaneous/missed Artery, biopsy Bone marrow, biopsy Bone exostosis Brain/meninges, other than for tumor resection Breast, biopsy, not requiring microscopic evaluation of surgical margins Breast, reduction mammoplasty Bronchus, biopsy Cell block, any source Cervix, biopsy Colon, biopsy Duodenum, biopsy Endocervix, curettings/biopsy Endometrium, curettings/biopsy Esophagus, biopsy Extremity, amputation, etc.	Possible Denial; Medical Records Optional	Investigative	Documentation optional. Reviewed only when 88104, 88305, 88312 & 88361 are billed together with Barrett's Esophagus diagnosis.
88312	Special stain including interpretation and report; Group I for microorganisms (eg, acid fast, methenamine silver)	Possible Denial; Medical Records Optional	Investigative	Documentation optional. Reviewed only when 88104, 88305, 88312 & 88361 are billed together with Barrett's Esophagus diagnosis.
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	Possible Denial; Medical Records Optional	Investigative	Documentation optional. Reviewed only when 88104, 88305, 88312 & 88361 are billed together with Barrett's Esophagus diagnosis.

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88399	Unlisted surgical pathology procedure	Medical necessity review will be performed upon claims submission with supporting documentation.	Medical Necessity	Review required at claims submission; submit description of procedure with supporting documentation (including operative report if surgical) only for the date of service performed.
88749	Unlisted in vivo lab service	Medical necessity review will be performed upon claims submission with supporting documentation.	Medical Necessity	Review required at claims submission; submit description of procedure with supporting documentation (including operative report if surgical) only for the date of service performed.
89240	Unlisted miscellaneous pathology test	Medical necessity review will be performed upon claims submission with supporting documentation.	Medical Necessity	Review required at claims submission; submit description of procedure with supporting documentation (including operative report if surgical) only for the date of service performed.
89398	Unlisted reproductive medicine laboratory procedure	Medical necessity review will be performed upon claims submission with supporting documentation.	Medical Necessity	Review required at claims submission; submit description of procedure with supporting documentation (including operative report if surgical) only for the date of service performed.
90283	Immune globulin (IgIV), human, for intravenous use	Prior Authorization Required	Medical necessity including site of service	This drug requires review for site of service administration in addition to review for prior authorization/medical necessity. Submit history and physical and recent lab work.
90284	Immune globulin (SCIg), human, for use in subcutaneous infusions, 100 mg, each	Prior Authorization Required	Medical necessity including site of service	This drug requires review for site of service administration in addition to review for prior authorization/medical necessity. Submit history and physical and recent lab work.
90291	Cytomegalovirus immune globulin (CMV-IgIV), human, for intravenous use	Prior Authorization Required	Medical Necessity Review Required	Submit history and physical, documentation of medical necessity.

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90399	Unlisted immune globulin	Medical necessity review will be performed upon claims submission with supporting documentation.	Medical Necessity	Review required at claims submission; submit description of procedure with supporting documentation (including operative report if surgical) only for the date of service performed.
90749	Unlisted vaccine/toxoid	Medical necessity review will be performed upon claims submission with supporting documentation.	Medical Necessity	Review required at claims submission; submit description of procedure with supporting documentation (including operative report if surgical) only for the date of service performed.
90867	Therapeutic repetitive transcranial magnetic stimulation treatment; planning	Prior Authorization Required	Medical Necessity	History and physical, chart notes from ordering physician, treatment plan and results.
90868	Therapeutic repetitive transcranial magnetic stimulation treatment; delivery and management, per session	Prior Authorization Required	Medical Necessity	History and physical, chart notes from ordering physician, treatment plan and results.
90869	Therapeutic repetitive transcranial magnetic stimulation (TMS) treatment; subsequent motor threshold re-determination with delivery and management	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity and procedure report.
90882	Environmental intervention for medical management purposes on a psychiatric patient's behalf with agencies, employers, or institutions	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
90889	Preparation of report of patient's psychiatric status, history, treatment, or progress (other than for legal or consultative purposes) for other individuals, agencies, or insurance carriers	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.

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90899	Unlisted psychiatric service or procedure	Medical necessity review will be performed upon claims submission with supporting documentation.	Medical Necessity	Review required at claims submission; submit description of procedure with supporting documentation (including operative report if surgical) only for the date of service performed.
90999	Unlisted dialysis procedure, inpatient or outpatient	Medical necessity review will be performed upon claims submission with supporting documentation.	Medical Necessity	Review required at claims submission; submit description of procedure with supporting documentation (including operative report if surgical) only for the date of service performed.
91299	Unlisted diagnostic gastroenterology procedure	Medical necessity review will be performed upon claims submission with supporting documentation.	Medical Necessity	Review required at claims submission; submit description of procedure with supporting documentation (including operative report if surgical) only for the date of service performed.
92065	Orthoptic and/or pleoptic training, with continuing medical direction and evaluation	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
92066	Orthoptic training; under supervision of a physician or other qualified health care professional.	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
92250	Fundus photography with interpretation and report	Retrospective Review	Medical Necessity	Reviewed retrospectively only. Submit history and physical, documentation of medical necessity.
92499	Unlisted eye procedure	Medical necessity review will be performed upon claims submission with supporting documentation.	Medical Necessity	Review required at claims submission; submit description of procedure with supporting documentation (including operative report if surgical) only for the date of service performed.
92562	Loudness balance test, alternate binaural or monaural	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
92596	Ear protector attenuation measurements	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.

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92640	Diagnostic analysis with programming of auditory brainstem implant, per hour	Prior Authorization Required	Medical Necessity	History and physical, office notes from ordering physician for visits related to the billed service and results of testing performed.
92700	Unlisted otorhinolaryngological service or procedure	Medical necessity review will be performed upon claims submission with supporting documentation.	Medical Necessity	Review required at claims submission; submit description of procedure with supporting documentation (including operative report if surgical) only for the date of service performed.
92972	Percutaneous transluminal coronary lithotripsy (List separately in addition to code for primary procedure)	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
93228	External mobile cardiovascular telemetry with electrocardiographic recording, concurrent computerized real time data analysis and greater than 24 hours of accessible ECG data storage (retrievable with query) with ECG triggered and patient selected events transmitted to a remote attended surveillance center for up to 30 days; review and interpretation with report by a physician or other qualified health care professional	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.

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93229	External mobile cardiovascular telemetry with electrocardiographic recording, concurrent computerized real time data analysis and greater than 24 hours of accessible ECG data storage (retrievable with query) with ECG triggered and patient selected events transmitted to a remote attended surveillance center for up to 30 days; technical support for connection and patient instructions for use, attended surveillance, analysis and transmission of daily and emergent data reports	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
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	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
93292	Interrogation device evaluation (in person) with physician analysis, review and report, includes connection, recording and disconnection per patient encounter; wearable defibrillator system	Pre-Service Review Required	Medical Necessity	Recent History and Physical, plan of care, and documentation of medical necessity
93303	Transthoracic echocardiography for congenital cardiac anomalies; complete	Prior Authorization Required	Advanced Imaging	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
93304	Transthoracic echocardiography for congenital cardiac anomalies; follow-up or limited study	Prior Authorization Required	Advanced Imaging	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.

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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 Required	Advanced Imaging	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
93307	Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, complete, without spectral or color Doppler echocardiography	Prior Authorization Required	Advanced Imaging	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
93308	Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, follow-up or limited study	Prior Authorization Required	Advanced Imaging	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
93312	Echocardiography, transesophageal, real-time with image documentation (2D) (with or without M-mode recording); including probe placement, image acquisition, interpretation and report	Prior Authorization Required	Advanced Imaging	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
93313	Echocardiography, transesophageal, real-time with image documentation (2D) (with or without M-mode recording); placement of transesophageal probe only	Prior Authorization Required	Advanced Imaging	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
93314	Echocardiography, transesophageal, real-time with image documentation (2D) (with or without M-mode recording); image acquisition, interpretation and report only	Prior Authorization Required	Advanced Imaging	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
93315	Transesophageal echocardiography for congenital cardiac anomalies; including probe placement, image acquisition, interpretation and report	Prior Authorization Required	Advanced Imaging	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
93316	Transesophageal echocardiography for congenital cardiac anomalies; placement of transesophageal probe only	Prior Authorization Required	Advanced Imaging	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
93317	Transesophageal echocardiography for congenital cardiac anomalies; image acquisition, interpretation and report only	Prior Authorization Required	Advanced Imaging	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
93350	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 and report;	Prior Authorization Required	Advanced Imaging	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
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 and report	Prior Authorization Required	Advanced Imaging	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
93454	Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation;	Prior Authorization Required	Medical necessity including site of service	Submit Site of Service, History and Physical, documentation of medical necessity, operative report.
93455	Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation	Prior Authorization Required	Medical necessity including site of service	Submit Site of Service, History and Physical, documentation of medical necessity, operative report.
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 Required	Medical necessity including site of service	Submit Site of Service, History and Physical, documentation of medical necessity, operative report
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 Required	Medical necessity including site of service	Submit Site of Service, History and Physical, documentation of medical necessity, operative report
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	Prior Authorization Required	Medical necessity including site of service	Submit Site of Service, History and Physical, documentation of medical necessity, operative report.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
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	Prior Authorization Required	Medical necessity including site of service	Submit Site of Service, History and Physical, documentation of medical necessity, operative report.
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	Prior Authorization Required	Medical necessity including site of service	Submit Site of Service, History and Physical, documentation of medical necessity, operative report.
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	Prior Authorization Required	Medical necessity including site of service	Submit Site of Service, History and Physical, documentation of medical necessity, operative report.
93580	Percutaneous transcatheter closure of congenital interatrial communication (ie, fonton fenestration, atrial septal defect) with implant	Prior Authorization Required	Medical Necessity	History and Physical, procedure report including name of transcatheter device used
93701	Bioimpedance thoracic electrical	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
93745	Initial set-up and programming by a physician of wearable cardioverter-defibrillator includes initial programming of system, establishing baseline electronic ECG, transmission of data to data repository	Pre-Service Review Required	Medical Necessity	Recent History and Physical, plan of care, and documentation of medical necessity

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93799	Unlisted cardiovascular service or procedure	Medical necessity review will be performed upon claims submission with supporting documentation.	Medical Necessity	Review required at claims submission; submit description of procedure with supporting documentation (including operative report if surgical) only for the date of service performed.
93895	Quantitative carotid intima media thickness and carotid atheroma evaluation, bilateral	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
93998	Unlisted noninvasive vascular diagnostic study	Medical necessity review will be performed upon claims submission with supporting documentation.	Medical Necessity	Review required at claims submission; submit description of procedure with supporting documentation (including operative report if surgical) only for the date of service performed.
94799	Unlisted pulmonary service or procedure	Medical necessity review will be performed upon claims submission with supporting documentation.	Medical Necessity	Review required at claims submission; submit description of procedure with supporting documentation (including operative report if surgical) only for the date of service performed.
95199	Unlisted allergy/clinical immunologic service or procedure	Medical necessity review will be performed upon claims submission with supporting documentation.	Medical Necessity	Review required at claims submission; submit description of procedure with supporting documentation (including operative report if surgical) only for the date of service performed.
95782	Polysomnography; younger than 6 years, sleep staging with 4 or more additional parameters of sleep, attended by a technologist	Prior Authorization Required	Sleep Study	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
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 Required	Sleep Study	Submit online review with Carelon at www.providerportal.com.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
95803	Actigraphy testing, recording, analysis, interpretation, and report (minimum of 72 hours to 14 consecutive days of recording)	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
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 Required	Sleep Study	Submit online review with Carelon at www.providerportal.com.
95807	Sleep study, simultaneous recording of ventilation, respiratory effort, ECG or heart rate, and oxygen saturation, attended by a technologist	Prior Authorization Required	Sleep Study	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
95808	Polysomnography; sleep staging with 1-3 additional parameters of sleep, attended by a technologist	Prior Authorization Required	Sleep Study	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
95810	Polysomnography; sleep staging with 4 or more additional parameters of sleep, attended by a technologist	Prior Authorization Required	Sleep Study	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
95811	Polysomnography; 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 Required	Sleep Study	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
95940	Continuous intraoperative neurophysiology monitoring in the operating room, one on one monitoring requiring personal attendance, each 15 minutes (List separately in addition to code for primary procedure)	Pre-Service Review Required	Medical Necessity	Submit history and physical, documentation of medical necessity and procedure report.
95941	Continuous intraoperative neurophysiology monitoring, from outside the operating room (remote or nearby) or for monitoring of more than one case while in the operating room, per hour (List separately in addition to code for primary procedure)	Pre-Service Review Required	Medical Necessity	Submit history and physical, documentation of medical necessity and procedure report.
95999	Unlisted neurological or neuromuscular diagnostic procedure	Medical necessity review will be performed upon claims submission with supporting documentation.	Medical Necessity	Review required at claims submission; submit description of procedure with supporting documentation (including operative report if surgical) only for the date of service performed.
96000	Comprehensive computer-based motion analysis by video-taping and 3-d kinematics	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
96001	Comprehensive computer-based motion analysis by video-taping and 3D kinematics; with dynamic plantar pressure measurements during walking	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
96002	Dynamic surface electromyography, during walking or other functional activities, 1-12 muscles	Possible Denial; Medical Records Optional	Investigative	Documentation optional.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
96004	Review and interpretation by physician or other qualified health care professional of comprehensive computer-based motion analysis, dynamic plantar pressure measurements, dynamic surface electromyography during walking or other functional activities, and dynamic fine wire electromyography, with written report	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
96161	Administration of caregiver-focused health risk assessment instrument (eg, depression inventory) for the benefit of the patient, with scoring and documentation, per standardized instrument	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
96379	Unlisted therapeutic, prophylactic, or diagnostic intravenous or intra-arterial injection or infusion	Medical necessity review will be performed upon claims submission with supporting documentation.	Medical Necessity	Review required at claims submission; submit description of procedure with supporting documentation (including operative report if surgical) only for the date of service performed.
96446	Chemotherapy administration into the peritoneal cavity via implanted port or catheter	Prior Authorization Required	Medical Necessity	Recent History and Physical, plan of care, and documentation of medical necessity
96547	Intraoperative hyperthermic intraperitoneal chemotherapy (HIPEC) procedure, including separate incision(s) and closure, when performed; first 60 minutes	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
96548	Intraoperative hyperthermic intraperitoneal chemotherapy (HIPEC) procedure, including separate incision(s) and closure, when performed; each additional 30 minutes	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.

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96549	Unlisted chemotherapy procedure	Medical necessity review will be performed upon claims submission with supporting documentation.	Medical Necessity	Review required at claims submission; submit description of procedure with supporting documentation (including operative report if surgical) only for the date of service performed.
96999	Unlisted special dermatological service or procedure	Medical necessity review will be performed upon claims submission with supporting documentation.	Medical Necessity	Review required at claims submission; submit description of procedure with supporting documentation (including operative report if surgical) only for the date of service performed.
97010	Application of a modality to 1 or more areas; hot or cold packs	Retrospective Review	Outpatient Rehabilitation	For Alaska plans: After initial visit, submit online review at www.evicore.com. For Washington plans: After the first 6 treatment visits in an episode of care, submit online review at www.evicore.com.
97012	Application of a modality to 1 or more areas; traction, mechanical	Retrospective Review	Outpatient Rehabilitation	For Alaska plans: After initial visit, submit online review at www.evicore.com. For Washington plans: After the first 6 treatment visits in an episode of care, submit online review at www.evicore.com.
97014	Application of a modality to 1 or more areas; electrical stimulation (unattended)	Retrospective Review	Outpatient Rehabilitation	For Alaska plans: After initial visit, submit online review at www.evicore.com. For Washington plans: After the first 6 treatment visits in an episode of care, submit online review at www.evicore.com.
97016	Application of a modality to 1 or more areas; vasopneumatic devices	Retrospective Review	Outpatient Rehabilitation	For Alaska plans: After initial visit, submit online review at www.evicore.com. For Washington plans: After the first 6 treatment visits in an episode of care, submit online review at www.evicore.com.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
97018	Application of a modality to 1 or more areas; paraffin bath	Retrospective Review	Outpatient Rehabilitation	For Alaska plans: After initial visit, submit online review at www.evicore.com. For Washington plans: After the first 6 treatment visits in an episode of care, submit online review at www.evicore.com.
97022	Application of a modality to 1 or more areas; whirlpool	Retrospective Review	Outpatient Rehabilitation	For Alaska plans: After initial visit, submit online review at www.evicore.com. For Washington plans: After the first 6 treatment visits in an episode of care, submit online review at www.evicore.com.
97024	Application of a modality to 1 or more areas; diathermy (eg, microwave)	Retrospective Review	Outpatient Rehabilitation	For Alaska plans: After initial visit, submit online review at www.evicore.com. For Washington plans: After the first 6 treatment visits in an episode of care, submit online review at www.evicore.com.
97026	Application of a modality to 1 or more areas; infrared	Retrospective Review	Outpatient Rehabilitation	For Alaska plans: After initial visit, submit online review at www.evicore.com. For Washington plans: After the first 6 treatment visits in an episode of care, submit online review at www.evicore.com.
97028	Application of a modality to 1 or more areas; ultraviolet	Retrospective Review	Outpatient Rehabilitation	For Alaska plans: After initial visit, submit online review at www.evicore.com. For Washington plans: After the first 6 treatment visits in an episode of care, submit online review at www.evicore.com.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
97032	Application of a modality to 1 or more areas; electrical stimulation (manual), each 15 minutes	Retrospective Review	Outpatient Rehabilitation	For Alaska plans: After initial visit, submit online review at www.evicore.com. For Washington plans: After the first 6 treatment visits in an episode of care, submit online review at www.evicore.com.
97033	Application of a modality to 1 or more areas; iontophoresis, each 15 minutes	Retrospective Review	Outpatient Rehabilitation	For Alaska plans: After initial visit, submit online review at www.evicore.com. For Washington plans: After the first 6 treatment visits in an episode of care, submit online review at www.evicore.com.
97034	Application of a modality to 1 or more areas; contrast baths, each 15 minutes	Retrospective Review	Outpatient Rehabilitation	For Alaska plans: After initial visit, submit online review at www.evicore.com. For Washington plans: After the first 6 treatment visits in an episode of care, submit online review at www.evicore.com.
97035	Application of a modality to 1 or more areas; ultrasound, each 15 minutes	Retrospective Review	Outpatient Rehabilitation	For Alaska plans: After initial visit, submit online review at www.evicore.com. For Washington plans: After the first 6 treatment visits in an episode of care, submit online review at www.evicore.com.
97036	Application of a modality to 1 or more areas; Hubbard tank, each 15 minutes	Retrospective Review	Outpatient Rehabilitation	For Alaska plans: After initial visit, submit online review at www.evicore.com. For Washington plans: After the first 6 treatment visits in an episode of care, submit online review at www.evicore.com.
97037	Application of a modality to 1 or more areas; low-level laser therapy (ie, nonthermal and non-ablative) for post-operative pain	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
97039	Unlisted modality (specify type and time if constant attendance)	Retrospective Review	Outpatient Rehabilitation	For Alaska plans: After initial visit, submit online review at www.evicore.com. For Washington plans: After the first 6 treatment visits in an episode of care, submit online review at www.evicore.com.
97110	Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility	Retrospective Review	Outpatient Rehabilitation	For Alaska plans: After initial visit, submit online review at www.evicore.com. For Washington plans: After the first 6 treatment visits in an episode of care, submit online review at www.evicore.com.
97112	Therapeutic procedure, 1 or more areas, each 15 minutes; neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities	Retrospective Review	Outpatient Rehabilitation	For Alaska plans: After initial visit, submit online review at www.evicore.com. For Washington plans: After the first 6 treatment visits in an episode of care, submit online review at www.evicore.com.
97113	Therapeutic procedure, 1 or more areas, each 15 minutes; aquatic therapy with therapeutic exercises	Retrospective Review	Outpatient Rehabilitation	For Alaska plans: After initial visit, submit online review at www.evicore.com. For Washington plans: After the first 6 treatment visits in an episode of care, submit online review at www.evicore.com.
97116	Therapeutic procedure, 1 or more areas, each 15 minutes; gait training (includes stair climbing)	Retrospective Review	Outpatient Rehabilitation	For Alaska plans: After initial visit, submit online review at www.evicore.com. For Washington plans: After the first 6 treatment visits in an episode of care, submit online review at www.evicore.com.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
97124	Therapeutic procedure, 1 or more areas, each 15 minutes; massage, including effleurage, petrissage and/or tapotement (stroking, compression, percussion)	Retrospective Review	Outpatient Rehabilitation	For Alaska plans: After initial visit, submit online review at www.evicore.com. For Washington plans: After the first 6 treatment visits in an episode of care, submit online review at www.evicore.com.
97140	Manual therapy techniques (eg, mobilization/ manipulation, manual lymphatic drainage, manual traction), 1 or more regions, each 15 minutes	Retrospective Review	Outpatient Rehabilitation	For Alaska plans: After initial visit, submit online review at www.evicore.com. For Washington plans: After the first 6 treatment visits in an episode of care, submit online review at www.evicore.com.
97150	Therapeutic procedure(s), group (2 or more individuals)	Retrospective Review	Outpatient Rehabilitation	For Alaska plans: After initial visit, submit online review at www.evicore.com. For Washington plans: After the first 6 treatment visits in an episode of care, submit online review at www.evicore.com.
97168	Re-evaluation of occupational therapy established plan of care. Typically, 30 minutes are spent face-to-face with the patient and/or family.	Retrospective Review	Outpatient Rehabilitation	For Alaska plans: After initial visit, submit online review at www.evicore.com. For Washington plans: After the first 6 treatment visits in an episode of care, submit online review at www.evicore.com.
97169	Athletic training evaluation, low complexity	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
97170	Athletic training evaluation, moderate complexity	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
97171	Athletic training evaluation, high complexity	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
97172	Re-evaluation of athletic training	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.

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97530	Therapeutic activities, direct (one-on-one) patient contact (use of dynamic activities to improve functional performance), each 15 minutes	Retrospective Review	Outpatient Rehabilitation	For Alaska plans: After initial visit, submit online review at www.evicore.com. For Washington plans: After the first 6 treatment visits in an episode of care, submit online review at www.evicore.com.
97533	Sensory integrative techniques to enhance sensory processing and promote adaptive responses to environmental demands, direct (one-on-one) patient contact by the provider, each 15 minutes	Retrospective Review	Outpatient Rehabilitation	For Alaska plans: After initial visit, submit online review at www.evicore.com. For Washington plans: After the first 6 treatment visits in an episode of care, submit online review at www.evicore.com.
97535	Self-care/home management training (eg, activities of daily living (ADL) and compensatory training, meal preparation, safety procedures, and instructions in use of assistive technology devices/adaptive equipment) direct one-on-one contact, each 15 minutes	Retrospective Review	Outpatient Rehabilitation	For Alaska plans: After initial visit, submit online review at www.evicore.com. For Washington plans: After the first 6 treatment visits in an episode of care, submit online review at www.evicore.com.
97537	Community/work reintegration training, direct one-on-one contact, each 15 minutes	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
97542	Wheelchair management (eg, assessment, fitting, training), each 15 minutes	Retrospective Review	Outpatient Rehabilitation	For Alaska plans: After initial visit, submit online review at www.evicore.com. For Washington plans: After the first 6 treatment visits in an episode of care, submit online review at www.evicore.com.
97545	Work hardening/conditioning; initial 2 hours	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
97546	Work hardening/conditioning; each additional hour (List separately in addition to code for primary procedure	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
97602	Removal of devitalized tissue from wound(s), non-selective debridement, without anesthesia (eg, wet-to-moist dressings, enzymatic, abrasion, larval therapy), including topical application(s), wound assessment, and instruction(s) for ongoing care, per session	Retrospective Review	Outpatient Rehabilitation	For Alaska plans: After initial visit, submit online review at www.evicore.com. For Washington plans: After the first 6 treatment visits in an episode of care, submit online review at www.evicore.com.
97750	Physical performance test or measurement (eg, musculoskeletal, functional capacity), with written report, each 15 minutes	Retrospective Review	Outpatient Rehabilitation	For Alaska plans: After initial visit, submit online review at www.evicore.com. For Washington plans: After the first 6 treatment visits in an episode of care, submit online review at www.evicore.com.
97755	Assistive technology assessment (eg, to restore, augment or compensate for existing function, optimize functional tasks and/or maximize environmental accessibility), direct one-on-one contact by provider, with written report, each 15 minutes	Retrospective Review	Outpatient Rehabilitation	For Alaska plans: After initial visit, submit online review at www.evicore.com. For Washington plans: After the first 6 treatment visits in an episode of care, submit online review at www.evicore.com.
97760	Orthotic(s) management and training (including assessment and fitting when not otherwise reported), upper extremity(s), lower extremity(s) and/or trunk, each 15 minutes	Retrospective Review	Outpatient Rehabilitation	For Alaska plans: After initial visit, submit online review at www.evicore.com. For Washington plans: After the first 6 treatment visits in an episode of care, submit online review at www.evicore.com.
97761	Prosthetic training, upper and/or lower extremity(s), each 15 minutes	Retrospective Review	Outpatient Rehabilitation	For Alaska plans: After initial visit, submit online review at www.evicore.com. For Washington plans: After the first 6 treatment visits in an episode of care, submit online review at www.evicore.com.

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97763	Orthotic(s)/prosthetic(s) management and/or training, upper extremity(ies), lower extremity(ies), and/or trunk, subsequent orthotic(s)/prosthetic(s) encounter, each 15 minutes	Retrospective Review	Outpatient Rehabilitation	For Alaska plans: After initial visit, submit online review at www.evicore.com. For Washington plans: After the first 6 treatment visits in an episode of care, submit online review at www.evicore.com.
97799	Unlisted physical medicine/rehabilitation service or procedure	Retrospective Review	Outpatient Rehabilitation	For Alaska plans: After initial visit, submit online review at www.evicore.com. For Washington plans: After the first 6 treatment visits in an episode of care, submit online review at www.evicore.com.
99026	Hospital mandated on call service; in-hospital, each hour	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
99027	Hospital mandated on call service; out-of-hospital, each hour	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
99056	Service(s) typically provided in the office, provided out of the office at request of patient, in addition to basic service	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
99070	Supplies and materials (except spectacles), provided by the physician or other qualified health care professional over and above those usually included with the office visit or other services rendered (list drugs, trays, supplies, or materials provided)	Medical necessity review will be performed upon claims submission with supporting documentation.	Medical Necessity	Review required at claims submission; submit description of procedure with supporting documentation (including operative report if surgical) only for the date of service performed.
99075	Medical testimony	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
99080	Special reports such as insurance forms, more than the information conveyed in the usual medical communications or standard reporting form	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
99183	Physician attendance and supervision of hyperbaric oxygen therapy, per session	Prior Authorization Required	Medical Necessity	History and Physical with medical necessity, treatment plan, treatments tried and failed and procedure report
99199	Unlisted special service or report	Medical necessity review will be performed upon claims submission with supporting documentation.	Medical Necessity	Review required at claims submission; submit description of procedure with supporting documentation (including operative report if surgical) only for the date of service performed.
99429	Unlisted preventive medicine svc	Medical necessity review will be performed upon claims submission with supporting documentation.	Medical Necessity	Review required at claims submission; submit description of procedure with supporting documentation (including operative report if surgical) only for the date of service performed.
99450	Basic life and/or disability examination that includes: Measurement of height, weight, and blood pressure; Completion of a medical history following a life insurance pro forma; Collection of blood sample and/or urinalysis complying with "chain of custody" protocols; and Completion of necessary documentation/certificates.	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
99455	Work related or medical disability examination by the treating physician that includes: Completion of a medical history commensurate with the patient's condition; Performance of an examination commensurate with the patient's condition; Formulation of a diagnosis, assessment of capabilities and stability, and calculation of impairment; Development of future medical treatment plan; and Completion of necessary documentation/certificates and report.	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
99456	Work related or medical disability examination by other than the treating physician that includes: Completion of a medical history commensurate with the patient's condition; Performance of an examination commensurate with the patient's condition; Formulation of a diagnosis, assessment of capabilities and stability, and calculation of impairment; Development of future medical treatment plan; and Completion of necessary documentation/certificates and report.	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
99499	Unlisted evaluation & management service	Medical necessity review will be performed upon claims submission with supporting documentation.	Medical Necessity	Review required at claims submission; submit description of procedure with supporting documentation (including operative report if surgical) only for the date of service performed.

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99600	Unlisted home visit service or procedure	Medical necessity review will be performed upon claims submission with supporting documentation.	Medical Necessity	Review required at claims submission; submit description of procedure with supporting documentation (including operative report if surgical) only for the date of service performed.
A0080	Nonemergency transportation, per mile - vehicle provided by volunteer (individual or organization), with no vested interest	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
A0090	Nonemergency transportation, per mile - vehicle provided by individual (family member, self, neighbor) with vested interest	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
A0100	Nonemergency transportation; taxi	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
A0110	Nonemergency transportation and bus, intra- or interstate carrier	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
A0120	Nonemergency transportation: mini-bus, mountain area transports, or other transportation systems	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
A0130	Nonemergency transportation: wheelchair van	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
A0140	Nonemergency transportation and air travel (private or commercial) intra- or interstate	Pre-Service Review Required	Medical Necessity	Recent History and Physical if applicable and letter of Medical Necessity documenting the need for the requested service
A0160	Nonemergency transportation: per mile - caseworker or social worker	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
A0170	Transportation ancillary: parking fees, tolls, other	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
A0180	Nonemergency transportation: ancillary: lodging, recipient	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
A0190	Nonemergency transportation: ancillary: meals, recipient	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.

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A0200	Nonemergency transportation: ancillary: lodging, escort	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
A0210	Nonemergency transportation: ancillary: meals, escort	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
A0426	Ambulance service, advanced life support, nonemergency transport, level 1 (ALS 1)	Pre-Service Review Required	Medical Necessity	Submit progress notes for last 24 hours prior to transport, physician order including medical records supporting rationale for transport
A0428	Ambulance service, basic life support, nonemergency transport, (BLS)	Pre-Service Review Required	Medical Necessity	Submit progress notes for last 24 hours prior to transport, physician order including medical records supporting rationale for transport
A0430	Ambulance service, conventional air services, transport, one way (fixed wing)	Pre-Service Review Required	Medical Necessity	Submit progress notes for last 24 hours prior to transport, physician order including medical records supporting rationale for transport
A0431	Ambulance service, conventional air services, transport, one way (rotary wing)	Pre-Service Review Required	Medical Necessity	Submit progress notes for last 24 hours prior to transport, physician order including medical records supporting rationale for transport
A0434	Specialty care transport (SCT)	Pre-Service Review Required	Medical Necessity	Recent History and Physical if applicable and letter of Medical Necessity documenting the need for the requested service
A0435	Fixed wing air mileage, per statute mile	Pre-Service Review Required	Medical Necessity	Recent History and Physical if applicable and letter of Medical Necessity documenting the need for the requested service
A0436	Rotary wing air mileage, per statute mile	Pre-Service Review Required	Medical Necessity	Recent History and Physical if applicable and letter of Medical Necessity documenting the need for the requested service

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A0888	Noncovered ambulance mileage, per mile (e.g., for miles traveled beyond closest appropriate facility)	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
A0999	Unlisted ambulance service	Medical necessity review will be performed upon claims submission with supporting documentation.	Medical Necessity	Upon claims submission Medical necessity review will be performed. Submit documentation to describe the services and include the transport record.
A2001	InnovaMatrix AC, per sq cm	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
A2002	Mirragen Advanced Wound Matrix, per sq cm	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
A2004	XCelliStem, per sq cm	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
A2005	Microlyte Matrix, per sq cm	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
A2006	NovoSorb SynPath dermal matrix, per sq cm	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
A2007	Restrata, per sq cm	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
A2008	TheraGenesis, per sq cm	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
A2009	Symphony, per sq cm	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
A2010	Apis, per sq cm	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
A2011	Supra SDRM, per square centimeter	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
A2012	Suprathel, per square centimeter	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
A2013	InnovaMatrix FS, per square centimeter	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
A2014	Omeza Collagen Matrix, per 100 mg	Possible Denial; Medical Records Optional	Investigative	Documentation optional.

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A2015	Phoenix Wound Matrix, per sq cm	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
A2016	PermeaDerm B, per sq cm	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
A2017	PermeaDerm Glove, each	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
A2018	PermeaDerm C, per sq cm	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
A2019	Kerecis Omega3 Marigen Shield, per square centimeter	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
A2020	Ac5 Advanced Wound System (AC5)	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
A2021	Neomatrix, per square centimeter	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
A2022	Innovaburn or Innovamatrix XL, per square centimeter	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
A2023	Innovamatrix PD, 1 mg.	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
A2024	Resolve matrix or Xenopatch, per square centimeter	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
A2025	Miro3D, per cubic centimeter	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
A2026	Restrata minimatrix, 5 mg	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
A2027	Matriderm, per square centimeter	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
A2028	Micromatrix flex, per mg	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
A2029	Mirotract wound matrix sheet, per cubic centimeter	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
A2030	Miro3d fibers, per milligram	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
A2031	Mirodry wound matrix, per square centimeter	Possible Denial; Medical Records Optional	Investigative	Documentation optional.

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A2032	Myriad matrix, per square centimeter	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
A2033	Myriad morcells, 4 milligrams	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
A2034	Foundation drs solo, per square centimeter	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
A2035	Corplex p or theracor p or allacor p, per milligram	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
A4100	Skin substitute, FDA cleared as a device, not otherwise specified	Medical necessity review will be performed upon claims submission with supporting documentation.	Medical Necessity	Review required at claims submission; submit description of procedure with supporting documentation (including operative report if surgical) only for the date of service performed.
A4244	Alcohol or peroxide, per pint	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
A4246	Betadine or pHisoHex solution, per pint	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
A4247	Betadine or iodine swabs/wipes, per box	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
A4290	Sacral nerve stimulation test lead, each	Pre-Service Review Required	Medical Necessity	Submit history and physical, documentation of medical necessity and procedure report.
A4335	Incontinence supply; miscellaneous	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
A4438	Adhesive clip applied to the skin to secure external electrical nerve stimulator controller, each	Retrospective Review	Medical Necessity	Submit history and physical, documentation of medical necessity and procedure report.
A4457	Enema tube, with or without adapter, any type, replacement only, each	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
A4468	Exsufflation belt, includes all supplies and accessories	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
A4520	Incontinence garment, any type, (e.g., brief, diaper), each	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.

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A4540	Distal transcutaneous electrical nerve stimulator, stimulates peripheral nerves of the upper arm	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
A4541	Monthly supplies for use of device coded at E0733	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
A4542	Supplies and accessories for external upper limb tremor stimulator of the peripheral nerves of the wrist	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
A4543	Supplies for transcutaneous electrical nerve stimulator, for nerves in the auricular region, per month	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
A4544	Electrode for external lower extremity nerve stimulator for restless legs syndrome	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
A4545	Supplies and accessories for external tibial nerve stimulator (e.g., socks, gel pads, electrodes, etc.), needed for one month	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
A4553	Non-disposable underpads, all sizes	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
A4554	Disposable underpads, all sizes	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
A4555	Electrode/transducer for use with electrical stimulation device used for cancer treatment, replacement only	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
A4563	Rectal control system for vaginal insertion, for long term use, includes pump and all supplies and accessories, any type each	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
A4575	Topical hyperbaric oxygen chamber, disposable	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
A4593	Neuromodulation stimulator system, adjunct to rehabilitation therapy regime	Possible Denial; Medical Records Optional	Investigative	Documentation optional.

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A4594	Neuromodulation stimulator system, adjunct to rehabilitation therapy regime, mouthpiece each	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
A4596	Cranial electrotherapy stimulation (CES) system supplies and accessories, per month	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
A4604	Tubing with integrated heating element for use with positive airway pressure device	Compliance	Sleep Devices and Equipment	Compliance information is required for sleep apnea equipment supplies. Submit online review with Carelon at www.providerportal.com during rental period. Post rental period and diagnosis other than sleep apnea, no review required.
A4660	Sphygmomanometer/blood pressure apparatus with cuff and stethoscope	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
A4663	Blood pressure cuff only	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
A4670	Automatic blood pressure monitor	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
A4931	Oral thermometer, reusable, any type, each	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
A4932	Rectal thermometer, reusable, any type, each	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
A6460	Synthetic resorbable wound dressing, sterile, pad size 16 sq in or less, without adhesive border, each dressing	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
A6461	Synthetic resorbable wound dressing, sterile, pad size more than 16 sq in but less than or equal to 48 sq in, without adhesive border, each dressing	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
A6530	Gradient compression stocking, below knee, 18-30 mm Hg, each	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
A6533	Gradient compression stocking, thigh length, 18-30 mm Hg, each	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.

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A6536	Gradient compression stocking, full-length/chap style, 18-30 mm Hg, each	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
A6539	Gradient compression stocking, waist length, 18-30 mm Hg, each	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
A7021	Supplies and accessories for lung expansion airway clearance, continuous high frequency oscillation, and nebulization device (e.g., handset, nebulizer kit, biofilter)	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
A7023	Mechanical allergen particle barrier/inhalation filter, cream, nasal, topical	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
A7027	Combination oral/nasal mask, used with continuous positive airway pressure device, each	Compliance	Sleep Devices and Equipment	Compliance information is required for sleep apnea equipment supplies. Submit online review with Carelon at www.providerportal.com during rental period. Post rental period and diagnosis other than sleep apnea, no review required.
A7028	Oral cushion for combination oral/nasal mask, replacement only, each	Compliance	Sleep Devices and Equipment	Compliance information is required for sleep apnea equipment supplies. Submit online review with Carelon at www.providerportal.com during rental period. Post rental period and diagnosis other than sleep apnea, no review required.
A7029	Nasal pillows for combination oral/nasal mask, replacement only, pair	Compliance	Sleep Devices and Equipment	Compliance information is required for sleep apnea equipment supplies. Submit online review with Carelon at www.providerportal.com during rental period. Post rental period and diagnosis other than sleep apnea, no review required.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
A7030	Full face mask used with positive airway pressure device, each	Compliance	Sleep Devices and Equipment	Compliance information is required for sleep apnea equipment supplies. Submit online review with Carelon at www.providerportal.com during rental period. Post rental period and diagnosis other than sleep apnea, no review required.
A7031	Face mask interface, replacement for full face mask, each	Compliance	Sleep Devices and Equipment	Compliance information is required for sleep apnea equipment supplies. Submit online review with Carelon at www.providerportal.com during rental period. Post rental period and diagnosis other than sleep apnea, no review required.
A7032	Cushion for use on nasal mask interface, replacement only, each	Compliance	Sleep Devices and Equipment	Compliance information is required for sleep apnea equipment supplies. Submit online review with Carelon at www.providerportal.com during rental period. Post rental period and diagnosis other than sleep apnea, no review required.
A7033	Pillow for use on nasal cannula type interface, replacement only, pair	Compliance	Sleep Devices and Equipment	Compliance information is required for sleep apnea equipment supplies. Submit online review with Carelon at www.providerportal.com during rental period. Post rental period and diagnosis other than sleep apnea, no review required.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
A7034	Nasal interface (mask or cannula type) used with positive airway pressure device, with or without head strap	Compliance	Sleep Devices and Equipment	Compliance information is required for sleep apnea equipment supplies. Submit online review with Carelon at www.providerportal.com during rental period. Post rental period and diagnosis other than sleep apnea, no review required.
A7035	Headgear used with positive airway pressure device	Compliance	Sleep Devices and Equipment	Compliance information is required for sleep apnea equipment supplies. Submit online review with Carelon at www.providerportal.com during rental period. Post rental period and diagnosis other than sleep apnea, no review required.
A7036	Chinstrap used with positive airway pressure device	Compliance	Sleep Devices and Equipment	Compliance information is required for sleep apnea equipment supplies. Submit online review with Carelon at www.providerportal.com during rental period. Post rental period and diagnosis other than sleep apnea, no review required.
A7037	Tubing used with positive airway pressure device	Compliance	Sleep Devices and Equipment	Compliance information is required for sleep apnea equipment supplies. Submit online review with Carelon at www.providerportal.com during rental period. Post rental period and diagnosis other than sleep apnea, no review required.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
A7038	Filter, disposable, used with positive airway pressure device	Compliance	Sleep Devices and Equipment	Compliance information is required for sleep apnea equipment supplies. Submit online review with Carelon at www.providerportal.com during rental period. Post rental period and diagnosis other than sleep apnea, no review required.
A7039	Filter, nondisposable, used with positive airway pressure device	Compliance	Sleep Devices and Equipment	Compliance information is required for sleep apnea equipment supplies. Submit online review with Carelon at www.providerportal.com during rental period. Post rental period and diagnosis other than sleep apnea, no review required.
A7044	Oral interface used with positive airway pressure device, each	Compliance	Sleep Devices and Equipment	Compliance information is required for sleep apnea equipment supplies. Submit online review with Carelon at www.providerportal.com during rental period. Post rental period and diagnosis other than sleep apnea, no review required.
A7045	Exhalation port with or without swivel used with accessories for positive airway devices, replacement only	Compliance	Sleep Devices and Equipment	Compliance information is required for sleep apnea equipment supplies. Submit online review with Carelon at www.providerportal.com during rental period. Post rental period and diagnosis other than sleep apnea, no review required.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
A7046	Water chamber for humidifier, used with positive airway pressure device, replacement, each	Compliance	Sleep Devices and Equipment	Compliance information is required for sleep apnea equipment supplies. Submit online review with Carelon at www.providerportal.com during rental period. Post rental period and diagnosis other than sleep apnea, no review required.
A7049	Expiratory positive airway pressure intranasal resistance valve	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
A9150	Nonprescription drugs	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
A9152	Single vitamin/mineral/trace element, oral, per dose, not otherwise specified	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
A9153	Multiple vitamins, with or without minerals and trace elements, oral, per dose, not otherwise specified	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
A9180	Pediculosis (lice infestation) treatment, topical, for administration by patient/caretaker	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
A9268	Programmer for transient, orally ingested capsule	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
A9269	Programable, transient, orally ingested capsule, for use with external programmer, per month	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
A9270	Noncovered item or service	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
A9273	Cold or hot fluid bottle, ice cap or collar, heat and/or cold wrap, any type	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
A9275	Home glucose disposable monitor, includes test strips	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
A9279	Monitoring feature/device, stand-alone or integrated, any type, includes all accessories, components and electronics, not otherwise classified	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.

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A9280	Alert or alarm device, not otherwise classified	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
A9281	Reaching/grabbing device, any type, any length, each	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
A9282	Wig, any type, each	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
A9286	Hygienic item or device, disposable or non-disposable, any type, each	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
A9291	Prescription digital cognitive and/or behavioral therapy, FDA cleared, per course of treatment	Pre-Service Review Required	Investigative	Submit history and physical, documentation of medical necessity.
A9292	Prescription digital visual therapy, software-only, FDA cleared, per course of treatment	Pre-Service Review Required	Investigative	Submit history and physical, documentation of medical necessity and procedure report.
A9300	Exercise equipment	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
A9513	Lutetium lu 177, dotatate, therapeutic, 1 millicurie	Prior Authorization Required	Medical Necessity	History and Physical, plan of care and procedure report
A9584	Iodine I-123 ioflupane, diagnostic, per study dose, up to 5 millicuries	Prior Authorization Required	Medical Necessity	Submit History and Physical, medical necessity documentation.
A9607	Lutetium Lu 177 vipivotide tetraxetan, therapeutic, 1 mCi	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity and procedure report.
A9615	Injection, pegulicianine, 1 mg	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
A9699	Radiopharmaceutical, therapeutic, not otherwise classified	Medical necessity review will be performed upon claims submission with supporting documentation.	Medical Necessity	Review required at claims submission; submit description of procedure with supporting documentation (including operative report if surgical) only for the date of service performed.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
A9900	Miscellaneous DME supply, accessory, and/or service component of another HCPCS code	Medical necessity review will be performed upon claims submission with supporting documentation.	Medical Necessity	Review required at claims submission; submit description of procedure with supporting documentation (including operative report if surgical) only for the date of service performed.
A9901	DME delivery, set up, and/or dispensing service component of another HCPCS code	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
A9999	Miscellaneous DME supply or accessory, not otherwise specified	Medical necessity review will be performed upon claims submission with supporting documentation.	Medical Necessity	Review required at claims submission; submit description of procedure with supporting documentation (including operative report if surgical) only for the date of service performed.
B4100	Food thickener, administered orally, per oz	Retrospective Review	Medical Necessity (only when delivered orally)	Only covered when delivered by feeding tube or (if oral) for diagnosis that are considered medically necessary.
B4102	Enteral formula, for adults, used to replace fluids and electrolytes (e.g., clear liquids), 500 ml = 1 unit	Retrospective Review	Medical Necessity (only when delivered orally)	Only covered when delivered by feeding tube or (if oral) for diagnosis that are considered medically necessary.
B4103	Enteral formula, for pediatrics, used to replace fluids and electrolytes (e.g., clear liquids), 500 ml = 1 unit	Retrospective Review	Medical Necessity (only when delivered orally)	Only covered when delivered by feeding tube or (if oral) for diagnosis that are considered medically necessary.
B4104	Additive for enteral formula (e.g., fiber)	Retrospective Review	Medical Necessity (only when delivered orally)	Only covered when delivered by feeding tube or (if oral) for diagnosis that are considered medically necessary.
B4105	In-line cartridge containing digestive enzyme(s) for enteral feeding, each	Possible Denial; Medical Records Optional	Medical Necessity	Only covered for diagnoses that are considered medically necessary otherwise considered investigational.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
B4149	Enteral formula, manufactured blenderized natural foods with intact nutrients, includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit	Retrospective Review	Medical Necessity (only when delivered orally)	Only covered when delivered by feeding tube or (if oral) for diagnosis that are considered medically necessary.
B4150	Enteral formula, nutritionally complete with intact nutrients, includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit	Retrospective Review	Medical Necessity (only when delivered orally)	Only covered when delivered by feeding tube or (if oral) for diagnosis that are considered medically necessary.
B4152	Enteral formula, nutritionally complete, calorically dense (equal to or greater than 1.5 kcal/ml) with intact nutrients, includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit	Retrospective Review	Medical Necessity (only when delivered orally)	Only covered when delivered by feeding tube or (if oral) for diagnosis that are considered medically necessary.
B4153	Enteral formula, nutritionally complete, hydrolyzed proteins (amino acids and peptide chain), includes fats, carbohydrates, vitamins and minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit	Retrospective Review	Medical Necessity (only when delivered orally)	Only covered when delivered by feeding tube or (if oral) for diagnosis that are considered medically necessary.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
B4154	Enteral formula, nutritionally complete, for special metabolic needs, excludes inherited disease of metabolism, includes altered composition of proteins, fats, carbohydrates, vitamins and/or minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit	Retrospective Review	Medical Necessity (only when delivered orally)	Only covered when delivered by feeding tube or (if oral) for diagnosis that are considered medically necessary.
B4155	Enteral formula, nutritionally incomplete/modular nutrients, includes specific nutrients, carbohydrates (e.g., glucose polymers), proteins/amino acids (e.g., glutamine, arginine), fat (e.g., medium chain triglycerides) or combination, administered through an enteral feeding tube, 100 calories = 1 unit	Retrospective Review	Medical Necessity (only when delivered orally)	Only covered when delivered by feeding tube or (if oral) for diagnosis that are considered medically necessary.
B4157	Enteral formula, nutritionally complete, for special metabolic needs for inherited disease of metabolism, includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit	Retrospective Review	Medical Necessity (only when delivered orally)	Only covered when delivered by feeding tube or (if oral) for diagnosis that are considered medically necessary.
B4158	Enteral formula, for pediatrics, nutritionally complete with intact nutrients, includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber and/or iron, administered through an enteral feeding tube, 100 calories = 1 unit	Retrospective Review	Medical Necessity (only when delivered orally)	Only covered when delivered by feeding tube or (if oral) for diagnosis that are considered medically necessary.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
B4159	Enteral formula, for pediatrics, nutritionally complete soy based with intact nutrients, includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber and/or iron, administered through an enteral feeding tube, 100 calories = 1 unit	Retrospective Review	Medical Necessity (only when delivered orally)	Only covered when delivered by feeding tube or (if oral) for diagnosis that are considered medically necessary.
B4160	Enteral formula, for pediatrics, nutritionally complete calorically dense (equal to or greater than 0.7 kcal/ml) with intact nutrients, includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit	Retrospective Review	Medical Necessity (only when delivered orally)	Only covered when delivered by feeding tube or (if oral) for diagnosis that are considered medically necessary.
B4161	Enteral formula, for pediatrics, hydrolyzed/amino acids and peptide chain proteins, includes fats, carbohydrates, vitamins and minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit	Retrospective Review	Medical Necessity (only when delivered orally)	Only covered when delivered by feeding tube or (if oral) for diagnosis that are considered medically necessary.
B4162	Enteral formula, for pediatrics, special metabolic needs for inherited disease of metabolism, includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit	Retrospective Review	Medical Necessity (only when delivered orally)	Only covered when delivered by feeding tube or (if oral) for diagnosis that are considered medically necessary.
C1052	Hemostatic agent, gastrointestinal, topical	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
C1062	Intravertebral body fracture augmentation with implant (e.g., metal, polymer)	Pre-Service Review Required	Medical Necessity	Submit history and physical, documentation of medical necessity and procedure report.

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C1605	Pacemaker, leadless, dual chamber (right atrial and right ventricular implantable components), rate-responsive, including all necessary components for implantation	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
C1726	Catheter, balloon dilatation, nonvascular	Retrospective Review	Medical Necessity	Submit history and physical, documentation of medical necessity and procedure report.
C1735	Catheter(s), intravascular for renal denervation, radiofrequency, including all single use system components	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
C1736	Catheter(s), intravascular for renal denervation, ultrasound, including all single use system components	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
C1737	Joint fusion and fixation device(s), sacroiliac and pelvis, including all system components (implantable)	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
C1761	Catheter, transluminal intravascular lithotripsy, coronary	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
C1767	Generator, neurostimulator (implantable), nonrechargeable	Retrospective Review	Medical Necessity	Submit history and physical, documentation of medical necessity and procedure report.
C1778	Lead, neurostimulator (implantable)	Retrospective Review	Medical Necessity	Submit history and physical, documentation of medical necessity and procedure report.
C1787	Patient programmer, neurostimulator	Retrospective Review	Medical Necessity	Submit history and physical, documentation of medical necessity and procedure report.
C1813	Prosthesis, penile, inflatable	Non-covered Service	Benefit Exception	Submit records only when member's contract indicates coverage. Beginning 1/1/22 code will require review for WA members when submitted for gender transition/affirmation surgery unless otherwise specified by contract.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
C1816	Receiver and/or transmitter, neurostimulator (implantable)	Retrospective Review	Medical Necessity	Submit history and physical, documentation of medical necessity and procedure report.
C1820	Generator, neurostimulator (implantable), with rechargeable battery and charging system	Retrospective Review	Medical Necessity	Submit history and physical, documentation of medical necessity and procedure report.
C1821	Interspinous process distraction device (implantable)	Retrospective Review	Investigative	Submit history and physical, documentation of medical necessity and procedure report.
C1822	Generator, neurostimulator (implantable), high frequency, with rechargeable battery and charging system	Retrospective Review	Medical Necessity	Submit history and physical, documentation of medical necessity and procedure report.
C1826	Generator, neurostimulator (implantable), includes closed feedback loop leads and all implantable components, with rechargeable battery and charging system	Retrospective Review	Medical Necessity	Submit history and physical, documentation of medical necessity and procedure report.
C1827	Generator, neurostimulator (implantable), nonrechargeable, with implantable stimulation lead and external paired stimulation controller	Retrospective Review	Medical Necessity	Submit history and physical, documentation of medical necessity and procedure report.
C1832	Autograft suspension, including cell processing and application, and all system components	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
C1833	Monitor, cardiac, including intracardiac lead and all system components (implantable)	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
C1883	Adaptor/extension, pacing lead or neurostimulator lead (implantable)	Retrospective Review	Medical Necessity	Submit history and physical, documentation of medical necessity and procedure report.
C1884	Embolization protective system	Retrospective Review	Investigative	Submit history and physical, documentation of medical necessity and procedure report.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
C1897	Lead, neurostimulator test kit (implantable)	Retrospective Review	Medical Necessity	Submit history and physical, documentation of medical necessity and procedure report.
C2596	Probe, image guided, robotic, waterjet ablation	Retrospective Review	Investigative	Submit history and physical, documentation of medical necessity and procedure report.
C2614	Probe, percutaneous lumbar discectomy	Retrospective Review	Investigative	Submit history and physical, documentation of medical necessity and procedure report.
C2616	Brachytherapy source, nonstranded, yttrium-90, per source	Retrospective Review	Medical Necessity	Submit history and physical, documentation of medical necessity and procedure report.
C2622	Prosthesis, penile, noninflatable	Non-covered Service	Benefit Exception	Submit records only when member's contract indicates coverage. Beginning 1/1/22 code will require review for WA members when submitted for gender transition/affirmation surgery unless otherwise specified by contract.
C2625	Stent, noncoronary, temporary, with delivery system	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
C7504	Percutaneous vertebroplasties (bone biopsies included when performed), first cervicothoracic and any additional cervicothoracic or lumbosacral vertebral bodies, unilateral or bilateral injection, inclusive of all imaging guidance	Retrospective Review	Medical Necessity	Submit history and physical, documentation of medical necessity and procedure report.
C7505	Percutaneous vertebroplasties (bone biopsies included when performed), first lumbosacral and any additional cervicothoracic or lumbosacral vertebral bodies, unilateral or bilateral injection, inclusive of all imaging guidance	Retrospective Review	Medical Necessity	Submit history and physical, documentation of medical necessity and procedure report.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
C7507	Percutaneous vertebral augmentations, first thoracic and any additional thoracic or lumbar vertebral bodies, including cavity creations (fracture reductions and bone biopsies included when performed) using mechanical device (e.g., kyphoplasty), unilateral or bilateral cannulations, inclusive of all imaging guidance	Retrospective Review	Medical Necessity	Submit history and physical, documentation of medical necessity.
C7508	Percutaneous vertebral augmentations, first lumbar and any additional thoracic or lumbar vertebral bodies, including cavity creations (fracture reductions and bone biopsies included when performed) using mechanical device (e.g., kyphoplasty), unilateral or bilateral cannulations, inclusive of all imaging guidance	Retrospective Review	Medical Necessity	Submit history and physical, documentation of medical necessity.
C7516	Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, with endoluminal imaging of initial coronary vessel or graft using intravascular ultrasound (IVUS) or optical coherence tomography (OCT) during diagnostic evaluation and/or therapeutic intervention including imaging supervision, interpretation and report	Retrospective Review	Medical Necessity	Submit history and physical, documentation of medical necessity.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
C7517	Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, with iliac and/or femoral artery angiography, nonselective, bilateral or ipsilateral to catheter insertion, performed at the same time as cardiac catheterization and/or coronary angiography, includes positioning or placement of the catheter in the distal aorta or ipsilateral femoral or iliac artery, injection of dye, production of permanent images, and..	Retrospective Review	Medical Necessity	Submit history and physical, documentation of medical necessity.
C7518	Catheter placement in coronary artery(ies) 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 with endoluminal imaging of initial coronary vessel or graft using intravascular ultrasound (IVUS) or optical coherence tomography (OCT) during diagnostic....	Retrospective Review	Medical Necessity	Submit history and physical, documentation of medical necessity.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
C7519	Catheter placement in coronary artery(ies) 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 with intravascular doppler velocity and/or pressure derived coronary flow reserve measurement (initial coronary vessel or graft) during coronary angiography...	Retrospective Review	Medical Necessity	Submit history and physical, documentation of medical necessity.
C7520	Catheter placement in coronary artery(ies) 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) includes intraprocedural injection(s) for bypass graft angiography with iliac and/or femoral artery angiography, nonselective, bilateral or ipsilateral to catheter insertion, performed at the same time as cardiac...	Retrospective Review	Medical Necessity	Submit history and physical, documentation of medical necessity.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
C7521	Catheter placement in coronary artery(ies) for coronary angiography, including intraprocedural injection(s) for coronary angiography with right heart catheterization with endoluminal imaging of initial coronary vessel or graft using intravascular ultrasound (IVUS) or optical coherence tomography (OCT) during diagnostic evaluation and/or therapeutic intervention including imaging supervision, interpretation and repor	Retrospective Review	Medical Necessity	Submit history and physical, documentation of medical necessity.
C7522	Catheter placement in coronary artery(ies) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation with right heart catheterization, with intravascular doppler velocity and/or pressure derived coronary flow reserve measurement (initial coronary vessel or graft) during coronary angiography including pharmacologically induced stress	Retrospective Review	Medical Necessity	Submit history and physical, documentation of medical necessity.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
C7523	Catheter placement in coronary artery(ies) 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, with endoluminal imaging of initial coronary vessel or graft using intravascular ultrasound (IVUS) or optical coherence tomography (OCT) during diagnostic evaluation and/or therapeutic intervention including...	Retrospective Review	Medical Necessity	Submit history and physical, documentation of medical necessity.
C7524	Catheter placement in coronary artery(ies) 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, with intravascular doppler velocity and/or pressure derived coronary flow reserve measurement (initial coronary vessel or graft) during coronary angiography including pharmacologically induced stress	Retrospective Review	Medical Necessity	Submit history and physical, documentation of medical necessity.

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C7525	Catheter placement in coronary artery(ies) 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 with endoluminal imaging of initial coronary vessel or graft using intravascular...	Retrospective Review	Medical Necessity	Submit history and physical, documentation of medical necessity.
C7526	Catheter placement in coronary artery(ies) 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 with intravascular doppler velocity...	Retrospective Review	Medical Necessity	Submit history and physical, documentation of medical necessity.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
C7527	Catheter placement in coronary artery(ies) 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, with endoluminal imaging of initial coronary vessel or graft using intravascular ultrasound (IVUS) or optical coherence tomography (OCT) during diagnostic evaluation and/or therapeutic intervention...	Retrospective Review	Medical Necessity	Submit history and physical, documentation of medical necessity.
C7528	Catheter placement in coronary artery(ies) 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, with intravascular doppler velocity and/or pressure derived coronary flow reserve measurement (initial coronary vessel or graft) during coronary angiography including pharmacologically induced stress	Retrospective Review	Medical Necessity	Submit history and physical, documentation of medical necessity.

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C7529	Catheter placement in coronary artery(ies) 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 with intravascular doppler velocity and/or pressure derived coronary flow...	Retrospective Review	Medical Necessity	Submit history and physical, documentation of medical necessity.
C7531	Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(ies), unilateral, with transluminal angioplasty with intravascular ultrasound (initial noncoronary vessel) during diagnostic evaluation and/or therapeutic intervention, including radiological supervision and interpretation	Pre-Service Review Required	Medical Necessity	Submit history and physical, documentation of medical necessity and procedure report.
C7534	Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(ies), unilateral, with atherectomy, includes angioplasty within the same vessel, when performed with intravascular ultrasound (initial noncoronary vessel) during diagnostic evaluation and/or therapeutic intervention, including radiological supervision and interpretation	Pre-Service Review Required	Medical Necessity	Submit history and physical, documentation of medical necessity and procedure report.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
C7535	Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(ies), unilateral, with transluminal stent placement(s), includes angioplasty within the same vessel, when performed, with intravascular ultrasound (initial noncoronary vessel) during diagnostic evaluation and/or therapeutic intervention, including radiological supervision and interpretation	Pre-Service Review Required	Medical Necessity	Submit history and physical, documentation of medical necessity and procedure report.
C7552	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 with intravascular doppler velocity and/or pressure derived coronary flow reserve measurement...	Retrospective Review	Medical Necessity	Submit history and physical, documentation of medical necessity.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
C7553	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 with pharmacologic agent administration (e.g., inhaled nitric oxide...	Retrospective Review	Medical Necessity	Submit history and physical, documentation of medical necessity.
C7557	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 and intraprocedural coronary FFR with 3D functional mapping of color-coded FFR values for the coronary tree, derived from coronary angiogram data, for real-time review and interpretation of possible atherosclerotic	Retrospective Review	Medical Necessity	Submit history and physical, documentation of medical necessity.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
C7562	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 with intraprocedural coronary fractional flow reserve (ffr) with 3d functional mapping of color-coded ffr values for the coronary tree, derived from coronary angiogram data, for real-time review and interpretation of possible atherosclerotic stenosis(es) intervention	Pre-Service Review Required	Medical Necessity	Submit history and physical, documentation of medical necessity and procedure report.
C8001	3D anatomical segmentation imaging for preoperative planning, data preparation and transmission, obtained from previous diagnostic computed tomographic or magnetic resonance examination of the same anatomy	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
C8003	Implantation of medial knee extraarticular implantable shock absorber spanning the knee joint from distal femur to proximal tibia, open, includes measurements, positioning and adjustments, with imaging guidance (eg, fluoroscopy)	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
C9173	Injection, filgrastim-txid (nypozi), biosimilar, 1 microgram	Medical necessity review will be performed upon claims submission with supporting documentation.	Medical Necessity	Submit history and physical, documentation of medical necessity.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
C9301	Obecabtagene autoleucel, up to 400 million cd19 car-positive viable t cells, including leukapheresis and dose preparation procedures, per therapeutic dose	Medical necessity review will be performed upon claims submission with supporting documentation.	Medical Necessity	Submit history and physical, documentation of medical necessity.
C9303	Injection, zolbetuximab-clzb, 1 mg	Medical necessity review will be performed upon claims submission with supporting documentation.	Medical Necessity	Submit history and physical, documentation of medical necessity.
C9304	Injection, marstacimab-hncq, 0.5 mg	Medical necessity review will be performed upon claims submission with supporting documentation.	Medical Necessity	Submit history and physical, documentation of medical necessity.
C9352	Microporous collagen implantable tube (NeuraGen Nerve Guide), per cm length	Retrospective Review	Investigative	Submit history and physical, documentation of medical necessity and procedure report.
C9353	Microporous collagen implantable slit tube (NeuraWrap Nerve Protector), per cm length	Retrospective Review	Investigative	Submit history and physical, documentation of medical necessity and procedure report.
C9354	Acellular pericardial tissue matrix of nonhuman origin (Veritas), per sq cm	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
C9355	Collagen nerve cuff (NeuroMatrix), per 0.5 cm length	Retrospective Review	Investigative	Submit history and physical, documentation of medical necessity and procedure report.
C9356	Tendon, porous matrix of cross-linked collagen and glycosaminoglycan matrix (TenoGlide Tendon Protector Sheet), per sq cm	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
C9358	Dermal substitute, native, nondenatured collagen, fetal bovine origin (SurgiMend Collagen Matrix), per 0.5 sq cm	Possible Denial; Medical Records Optional	Investigative	Documentation optional.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
C9360	Dermal substitute, native, nondenatured collagen, neonatal bovine origin (SurgiMend Collagen Matrix), per 0.5 sq cm	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
C9361	Collagen matrix nerve wrap (NeuroMend Collagen Nerve Wrap), per 0.5 cm length	Retrospective Review	Investigative	Submit history and physical, documentation of medical necessity and procedure report.
C9363	Skin substitute (Integra Meshed Bilayer Wound Matrix), per sq cm	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
C9364	Porcine implant, Permacol, per sq cm	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
C9399	Unlisted unclassified drugs or biologicals	Medical necessity review will be performed upon claims submission with supporting documentation.		Review required at claims submission; submit description of procedure with supporting documentation (including operative report if surgical) only for the date of service performed.
C9727	Insertion of implants into the soft palate; minimum of three implants	Retrospective Review	Medical Necessity	Submit history and physical, documentation of medical necessity and procedure report.
C9751	Bronchoscopy, rigid or flexible, transbronchial ablation of lesion(s) by microwave energy, including fluoroscopic guidance, when performed, with computed tomography acquisition(s) and 3D rendering, computer-assisted, image-guided navigation, and endobronchial ultrasound (EBUS) guided transtracheal and/or transbronchial sampling (e.g., aspiration[s]/biopsy[ies]) and all mediastinal and/or hilar lymph node stations or structures and therapeutic intervention(s)	Retrospective Review	Medical Necessity	Submit history and physical, documentation of medical necessity and procedure report.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
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	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
C9764	Revascularization, endovascular, open or percutaneous, lower extremity artery(ies), except tibial/peroneal; with intravascular lithotripsy, includes angioplasty within the same vessel(s), when performed	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
C9765	Revascularization, endovascular, open or percutaneous, lower extremity artery(ies), except tibial/peroneal; with intravascular lithotripsy, and transluminal stent placement(s), includes angioplasty within the same vessel(s), when performed	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
C9766	Revascularization, endovascular, open or percutaneous, lower extremity artery(ies), except tibial/peroneal; with intravascular lithotripsy and atherectomy, includes angioplasty within the same vessel(s), when performed	Possible Denial; Medical Records Optional	Investigative	Documentation optional.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
C9767	Revascularization, endovascular, open or percutaneous, lower extremity artery(ies), except tibial/peroneal; with intravascular lithotripsy and transluminal stent placement(s), and atherectomy, includes angioplasty within the same vessel(s), when performed	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
C9772	Revascularization, endovascular, open or percutaneous, tibial/peroneal artery(ies), with intravascular lithotripsy, includes angioplasty within the same vessel(s), when performed	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
C9773	Revascularization, endovascular, open or percutaneous, tibial/peroneal artery(ies); with intravascular lithotripsy, and transluminal stent placement(s), includes angioplasty within the same vessel(s), when performed	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
C9774	Revascularization, endovascular, open or percutaneous, tibial/peroneal artery(ies); with intravascular lithotripsy and atherectomy, includes angioplasty within the same vessel(s), when performed	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
C9775	Revascularization, endovascular, open or percutaneous, tibial/peroneal artery(ies); with intravascular lithotripsy and transluminal stent placement(s), and atherectomy, includes angioplasty within the same vessel(s), when performed	Possible Denial; Medical Records Optional	Investigative	Documentation optional.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
C9777	Esophageal mucosal integrity testing by electrical impedance, transoral (list separately in addition to code for primary procedure)	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
C9781	Arthroscopy, shoulder, surgical; with implantation of subacromial spacer (e.g., balloon), includes debridement (e.g., limited or extensive), subacromial decompression, acromioplasty, and biceps tenodesis when performed	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
C9784	Gastric restrictive procedure, endoscopic sleeve gastroplasty, with esophagogastroduodenoscopy and intraluminal tube insertion, if performed, including all system and tissue anchoring components	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
C9785	Endoscopic outlet reduction, gastric pouch application, with endoscopy and intraluminal tube insertion, if performed, including all system and tissue anchoring components	Pre-Service Review Required	Investigative	Submit history and physical, documentation of medical necessity.
C9789	Instillation of antineoplastic pharmacologic/biologic agent into renal pelvis, any method, including all imaging guidance, including volumetric measurement if performed	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
C9792	Blinded or nonblinded procedure for symptomatic New York Heart Association Class II. III. IVA heart failure; transcatheter implantation of left atrial to coronary sinus	Possible Denial; Medical Records Optional	Investigative	Documentation optional.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
C9793	3D predictive model generation for pre-planning of a cardiac procedure, using data from cardiac computed tomographic angiography with report	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
C9807	Nerve stimulator, percutaneous, peripheral (e.g., sprint peripheral nerve stimulation system), including electrode and all disposable system components, non-opioid medical device (must be a qualifying medicare non-opioid medical device for post-surgical pain relief in accordance with section 4135 of the caa, 2023)	Medical necessity review will be performed upon claims submission with supporting documentation.	Medical Necessity	Submit history and physical, documentation of medical necessity.
C9808	Nerve cryoablation probe (e.g., cryoice, cryosphere, cryosphere max, cryoice cryosphere, cryoice cryo2), including probe and all disposable system components, non-opioid medical device (must be a qualifying medicare non-opioid medical device for post-surgical pain relief in accordance with section 4135 of the caa, 2023)	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
C9809	Cryoablation needle (e.g., iovera system), including needle/tip and all disposable system components, non-opioid medical device (must be a qualifying medicare non-opioid medical device for post-surgical pain relief in accordance with section 4135 of the caa, 2023)	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
D0240	Intraoral - occlusal radiographic image	Predetermination Recommended	Dental Necessity	Narrative describing the dental necessity for an intraoral - occlusal film

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
D0250	Extra-oral - 2D projection radiographic image created using a stationary radiation source, and detector	Predetermination Recommended	Dental Necessity	Narrative or description of the type of extraoral x-ray performed.
D0310	Sialography	Predetermination Recommended	Medical or Dental Service	Diagnosis or narrative describing the need for a sialography.
D0320	Temporomandibular joint arthrogram, including injection	Predetermination Recommended	Medical Necessity	Diagnosis or narrative describing the need for a temporomandibular joint arthrogram, including injection.
D0321	Other temporomandibular joint radiographic images, by report	Predetermination Recommended	Medical Necessity	Diagnosis or narrative describing the need for Other temporomandibular joint radiographic images.
D0322	Tomographic survey	Predetermination Recommended	Medical Necessity	Diagnosis and/or narrative of condition describing the need for a tomographic survey.
D0364	Cone beam CT capture and interpretation with limited field of view - less than one whole jaw	Prior Authorization Required	Medical Necessity	Complete the Dental Prior Authorization form: https://www.premera.com/documents/030000.pdf and FAX completed form to 425-918-5956 for review. Add diagnosis or narrative of condition (pathology or operative report if applicable)
D0365	Cone beam CT capture and interpretation with field of view of one full dental arch - mandible	Prior Authorization Required	Medical Necessity	Complete the Dental Prior Authorization form: https://www.premera.com/documents/030000.pdf and FAX completed form to 425-918-5956 for review. Add diagnosis or narrative of condition (pathology or operative report if applicable)

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
D0366	Cone beam CT capture and interpretation with field of view of one full dental arch - maxilla, with or without cranium	Prior Authorization Required	Medical Necessity	Complete the Dental Prior Authorization form: https://www.premera.com/documents/030000.pdf and FAX completed form to 425-918-5956 for review. Diagnosis or narrative of condition (pathology or operative report if applicable)
D0367	Cone beam CT capture and interpretation with field of view of both jaws; with or without cranium	Prior Authorization Required	Medical Necessity	Complete the Dental Prior Authorization form: https://www.premera.com/documents/030000.pdf and FAX completed form to 425-918-5956 for review. Diagnosis or narrative of condition (pathology or operative report if applicable)
D0368	Cone beam CT capture and interpretation for TMJ series including two or more exposures	Prior Authorization Required	Medical Necessity	Complete the Dental Prior Authorization form: https://www.premera.com/documents/030000.pdf and FAX completed form to 425-918-5956 for review. Diagnosis or narrative describing the need for a cone beam CT capture and interpretation for TMJ series including two or more exposures.
D0369	Maxillofacial MRI capture and interpretation	Prior Authorization Required	Medical Necessity	Complete the Dental Prior Authorization form: https://www.premera.com/documents/030000.pdf and FAX completed form to 425-918-5956 for review. Diagnosis or narrative of condition (pathology or operative report if applicable)
D0370	Maxillofacial ultrasound capture and interpretation	Predetermination Recommended	Medical or Dental Service	Diagnosis or narrative of condition (pathology or operative report if applicable)

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
D0371	Sialoendoscopy capture and interpretation	Predetermination Recommended	Medical or Dental Service	Diagnosis or narrative describing the need for a sialoendoscopy.
D0380	Cone beam CT image capture with limited field of view - less than one whole jaw	Prior Authorization Required	Medical Necessity	Complete the Dental Prior Authorization form: https://www.premera.com/documents/030000.pdf and FAX completed form to 425-918-5956 for review. Diagnosis or narrative of condition (pathology or operative report if applicable)
D0381	Cone beam CT image capture with field of view of one full dental arch - mandible	Prior Authorization Required	Medical Necessity	Complete the Dental Prior Authorization form: https://www.premera.com/documents/030000.pdf and FAX completed form to 425-918-5956 for review. Diagnosis or narrative of condition (pathology or operative report if applicable)
D0382	Cone beam CT image capture with field of view of one full dental arch - maxilla, with or without cranium	Prior Authorization Required	Medical Necessity	Complete the Dental Prior Authorization form: https://www.premera.com/documents/030000.pdf and FAX completed form to 425-918-5956 for review. Diagnosis or narrative of condition (pathology or operative report if applicable)
D0383	Cone beam CT image capture with field of view of both jaws, with or without cranium	Prior Authorization Required	Medical Necessity	Complete the Dental Prior Authorization form: https://www.premera.com/documents/030000.pdf and FAX completed form to 425-918-5956 for review. Diagnosis or narrative of condition (pathology or operative report if applicable)

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
D0384	Cone beam CT image capture for TMJ series including two or more exposures	Prior Authorization Required	Medical Necessity	Complete the Dental Prior Authorization form: https://www.premera.com/documents/030000.pdf and FAX completed form to 425-918-5956 for review. Diagnosis or narrative describing the need for a cone beam CT capture and interpretation for TMJ series including two or more exposures
D0385	Maxillofacial MRI image capture	Prior Authorization Required	Medical Necessity	Complete the Dental Prior Authorization form: https://www.premera.com/documents/030000.pdf and FAX completed form to 425-918-5956 for review. Diagnosis or narrative of condition (pathology or operative report if applicable)
D0386	Maxillofacial ultrasound image capture	Predetermination Recommended	Medical or Dental Service	Diagnosis or narrative of condition (pathology or operative report if applicable)
D0391	Interpretation of diagnostic image by a practitioner not associated with capture of the image, including report	Predetermination Recommended	Dental Necessity	Narrative and rationale for the proposed treatment.
D0394	Digital subtraction of two or more images or image volumes of the same modality	Predetermination Recommended	Dental Necessity	Narrative and/or chart notes.
D0415	Collection of microorganisms for culture and sensitivity	Predetermination Recommended	Dental Necessity	Diagnosis or narrative of condition (pathology or operative report if applicable)
D0416	viral culture	Predetermination Recommended	Medical or Dental Service	Diagnosis or narrative of condition (pathology or operative report if applicable)
D0417	Collection and preparation of saliva sample for laboratory diagnostic testing	Predetermination Recommended	Dental Necessity	Diagnosis or narrative of condition (pathology or operative report if applicable)

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
D0418	Analysis of saliva sample	Predetermination Recommended	Medical or Dental Service	Diagnosis or narrative of condition (pathology or operative report if applicable)
D0419	Assessment of salivary flow by measurement	Non-covered Service	Benefit Exception	Inclusive service, not separately reimbursable.
D0470	Diagnostic casts	Predetermination Recommended	Dental Necessity	Diagnosis or narrative describing the need for the diagnositic cast.
D0472	Accession of tissue, gross examination, preparation and transmission of written report	Predetermination Recommended	Medical or Dental Service	Diagnosis or narrative of condition (pathology or operative report if applicable)
D0473	Accession of tissue, gross and microscopic examination, preparation and transmission of written report	Predetermination Recommended	Medical or Dental Service	Diagnosis or narrative of condition (pathology or operative report if applicable)
D0474	Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report	Predetermination Recommended	Medical or Dental Service	Diagnosis or narrative of condition (pathology or operative report if applicable)
D0475	Decalcification procedure	Predetermination Recommended	Medical or Dental Service	Diagnosis or narrative of condition (pathology or operative report if applicable)
D0476	special stains for microorganisms	Predetermination Recommended	Medical or Dental Service	Diagnosis or narrative of condition (pathology or operative report if applicable)
D0477	special stains, not for microorganisms	Predetermination Recommended	Medical or Dental Service	Diagnosis or narrative of condition (pathology or operative report if applicable)
D0478	Immunohistochemical stains	Predetermination Recommended	Medical or Dental Service	Diagnosis or narrative of condition (pathology or operative report if applicable)
D0479	Tissue in-situ hybridization, including interpretation	Predetermination Recommended	Medical or Dental Service	Diagnosis or narrative of condition (pathology or operative report if applicable)

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D0480	Accession of exfoliative cytologic smears, microscopic examination, preparation and transmission of written report	Predetermination Recommended	Medical or Dental Service	Diagnosis or narrative of condition (pathology or operative report if applicable)
D0481	Electron microscopy	Predetermination Recommended	Medical or Dental Service	Diagnosis or narrative of condition (pathology or operative report if applicable)
D0482	Direct immunofluorescence	Predetermination Recommended	Medical or Dental Service	Diagnosis or narrative of condition (pathology or operative report if applicable)
D0483	Indirect immunofluorescence	Predetermination Recommended	Medical or Dental Service	Diagnosis or narrative of condition (pathology or operative report if applicable)
D0484	Consultation on slides prepared elsewhere	Predetermination Recommended	Medical or Dental Service	Diagnosis or narrative of condition (pathology or operative report if applicable)
D0485	Consultation, including preparation of slides from biopsy material supplied by referring source	Predetermination Recommended	Medical or Dental Service	Diagnosis or narrative of condition (pathology or operative report if applicable)
D0486	Laboratory accession of transepithelial cytologic sample, microscopic examination, preparation and transmission of written report	Predetermination Recommended	Medical or Dental Service	Diagnosis or narrative of condition (pathology or operative report if applicable)
D0502	Other oral pathology procedures, by report	Predetermination Recommended	Medical or Dental Service	Diagnosis or narrative of condition (pathology or operative report if applicable)
D0706	Intraoral – occlusal radiographic image – image capture only	Predetermination Recommended	Dental Necessity	Narrative describing the dental necessity for an intraoral - occlusal film
D2510	Inlay - metallic - one surface	Predetermination Recommended	Dental Necessity	Preoperative x-rays, a narrative describing existing restorations and areas of decay/defects, tooth surface, prep and seat dates, and indicate if there was any prior inlay or onlay (if so, need date of prior placement).

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
D2520	Inlay - metallic - two surfaces	Predetermination Recommended	Dental Necessity	Preoperative x-rays, a narrative describing existing restorations and areas of decay/defects, tooth surface, prep and seat dates, and indicate if there was any prior inlay or onlay (if so, need date of prior placement).
D2530	Inlay - metallic - three surface	Predetermination Recommended	Dental Necessity	Preoperative x-rays, a narrative describing existing restorations and areas of decay/defects, tooth surface, prep and seat dates, and indicate if there was any prior inlay or onlay (if so, need date of prior placement).
D2542	onlay - metallic - two surface	Predetermination Recommended	Dental Necessity	Preoperative x-rays, a narrative describing existing restorations and areas of decay/defects, tooth surface, prep and seat dates, and indicate if there was any prior inlay or onlay (if so, need date of prior placement).
D2543	onlay - metallic - three surfaces	Predetermination Recommended	Dental Necessity	Preoperative x-rays, a narrative describing existing restorations and areas of decay/defects, tooth surface, prep and seat dates, and indicate if there was any prior inlay or onlay (if so, need date of prior placement).
D2544	onlay - metallic - four or more surfaces	Predetermination Recommended	Dental Necessity	Preoperative x-rays, a narrative describing existing restorations and areas of decay/defects, tooth surface, prep and seat dates, and indicate if there was any prior inlay or onlay (if so, need date of prior placement).

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
D2610	Inlay - porcelain/ceramic - one surface	Predetermination Recommended	Dental Necessity	Preoperative x-rays, a narrative describing existing restorations and areas of decay/defects, tooth surface, prep and seat dates, and indicate if there was any prior inlay or onlay (if so, need date of prior placement).
D2620	Inlay - porcelain/ceramic - two surfaces	Predetermination Recommended	Dental Necessity	Preoperative x-rays, a narrative describing existing restorations and areas of decay/defects, tooth surface, prep and seat dates, and indicate if there was any prior inlay or onlay (if so, need date of prior placement).
D2630	Inlay - porcelain/ceramic - three surface	Predetermination Recommended	Dental Necessity	Preoperative x-rays, a narrative describing existing restorations and areas of decay/defects, tooth surface, prep and seat dates, and indicate if there was any prior inlay or onlay (if so, need date of prior placement).
D2642	onlay - porcelain/ceramic - two surface	Predetermination Recommended	Dental Necessity	Preoperative x-rays, a narrative describing existing restorations and areas of decay/defects, tooth surface, prep and seat dates, and indicate if there was any prior inlay or onlay (if so, need date of prior placement).
D2643	onlay - porcelain/ceramic - three surfaces	Predetermination Recommended	Dental Necessity	Preoperative x-rays, a narrative describing existing restorations and areas of decay/defects, tooth surface, prep and seat dates, and indicate if there was any prior inlay or onlay (if so, need date of prior placement).

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
D2644	onlay - porcelain/ceramic - four or more surfaces	Predetermination Recommended	Dental Necessity	Preoperative x-rays, a narrative describing existing restorations and areas of decay/defects, tooth surface, prep and seat dates, and indicate if there was any prior inlay or onlay (if so, need date of prior placement).
D2650	Inlay - resin-based composite - one surface	Predetermination Recommended	Dental Necessity	Preoperative x-rays, a narrative describing existing restorations and areas of decay/defects, tooth surface, prep and seat dates, and indicate if there was any prior inlay or onlay (if so, need date of prior placement).
D2651	Inlay - resin-based composite - two surfaces	Predetermination Recommended	Dental Necessity	Preoperative x-rays, a narrative describing existing restorations and areas of decay/defects, tooth surface, prep and seat dates, and indicate if there was any prior inlay or onlay (if so, need date of prior placement).
D2652	Inlay - resin-based composite - three surface	Predetermination Recommended	Dental Necessity	Preoperative x-rays, a narrative describing existing restorations and areas of decay/defects, tooth surface, prep and seat dates, and indicate if there was any prior inlay or onlay (if so, need date of prior placement).
D2662	Onlay, resin-based composite, two surfaces	Predetermination Recommended	Dental Necessity	Preoperative x-rays, a narrative describing existing restorations and areas of decay/defects, tooth surface, prep and seat dates, and indicate if there was any prior inlay or onlay (if so, need date of prior placement).

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
D2663	Onlay, resin-based composite, three surfaces	Predetermination Recommended	Dental Necessity	Preoperative x-rays, a narrative describing existing restorations and areas of decay/defects, tooth surface, prep and seat dates, and indicate if there was any prior inlay or onlay (if so, need date of prior placement).
D2664	Onlay, resin-based composite, four or more surfaces	Predetermination Recommended	Dental Necessity	Preoperative x-rays, a narrative describing existing restorations and areas of decay/defects, tooth surface, prep and seat dates, and indicate if there was any prior inlay or onlay (if so, need date of prior placement).
D2710	Crown - resin-based composite (indirect)	Predetermination Recommended	Dental Necessity	Preoperative x-rays, a narrative describing existing restorations and areas of decay/defects, prep and seat dates, and indicate if there was any prior inlay or onlay (if so, need date of prior placement).
D2712	Crown - 3/4 resin-based composite (indirect)	Predetermination Recommended	Dental Necessity	Preoperative x-rays, a narrative describing existing restorations and areas of decay/defects, prep and seat dates, and indicate if there was any prior inlay or onlay (if so, need date of prior placement).
D2720	Crown, Resin with High Noble Metal	Predetermination Recommended	Dental Necessity	Preoperative x-rays, a narrative describing existing restorations and areas of decay/defects, prep and seat dates, and indicate if there was any prior inlay or onlay (if so, need date of prior placement).

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
D2721	Crown, Resin, Predominantly Base Metal	Predetermination Recommended	Dental Necessity	Preoperative x-rays, a narrative describing existing restorations and areas of decay/defects, prep and seat dates, and indicate if there was any prior inlay or onlay (if so, need date of prior placement).
D2722	Crown, Resin with Noble Metal	Predetermination Recommended	Dental Necessity	Preoperative x-rays, a narrative describing existing restorations and areas of decay/defects, prep and seat dates, and indicate if there was any prior inlay or onlay (if so, need date of prior placement).
D2740	Porcelain/Ceramic Substrate	Predetermination Recommended	Dental Necessity	Preoperative x-rays, a narrative describing existing restorations and areas of decay/defects, prep and seat dates, and indicate if there was any prior inlay or onlay (if so, need date of prior placement).
D2750	Porcelain Fused to High Noble Metal	Predetermination Recommended	Dental Necessity	Preoperative x-rays, a narrative describing existing restorations and areas of decay/defects, prep and seat dates, and indicate if there was any prior inlay or onlay (if so, need date of prior placement).
D2751	Porcelain Fused to Predominantly Base Metal	Predetermination Recommended	Dental Necessity	Preoperative x-rays, a narrative describing existing restorations and areas of decay/defects, prep and seat dates, and indicate if there was any prior inlay or onlay (if so, need date of prior placement).

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
D2752	Porcelain Fused to Noble Metal	Predetermination Recommended	Dental Necessity	Preoperative x-rays, a narrative describing existing restorations and areas of decay/defects, prep and seat dates, and indicate if there was any prior inlay or onlay (if so, need date of prior placement).
D2753	Crown porcelain fused to titanium and titanium alloys	Predetermination Recommended	Dental Necessity	Preoperative x-rays, a narrative describing existing restorations and areas of decay/defects, prep and seat dates, and indicate if there was any prior inlay or onlay (if so, need date of prior placement).
D2780	Crown, 3/4 Cast High Noble Metal	Predetermination Recommended	Dental Necessity	Preoperative x-rays, a narrative describing existing restorations and areas of decay/defects, prep and seat dates, and indicate if there was any prior inlay or onlay (if so, need date of prior placement).
D2781	Crown, 3/4 Cast Predominantly Base Metal	Predetermination Recommended	Dental Necessity	Preoperative x-rays, a narrative describing existing restorations and areas of decay/defects, prep and seat dates, and indicate if there was any prior inlay or onlay (if so, need date of prior placement).
D2782	Crown, 3/4 Cast Noble Metal	Predetermination Recommended	Dental Necessity	Preoperative x-rays, a narrative describing existing restorations and areas of decay/defects, prep and seat dates, and indicate if there was any prior inlay or onlay (if so, need date of prior placement).

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
D2783	Crown 3/4 Porcelain/Ceramic. This procedure does not include facial veneers.	Predetermination Recommended	Dental Necessity	Preoperative x-rays, a narrative describing existing restorations and areas of decay/defects, prep and seat dates, and indicate if there was any prior inlay or onlay (if so, need date of prior placement).
D2790	Crown, Full Cast High Noble Metal	Predetermination Recommended	Dental Necessity	Preoperative x-rays, a narrative describing existing restorations and areas of decay/defects, prep and seat dates, and indicate if there was any prior inlay or onlay (if so, need date of prior placement).
D2791	Crown, Full Cast Predoninantly Base Metal	Predetermination Recommended	Dental Necessity	Preoperative x-rays, a narrative describing existing restorations and areas of decay/defects, prep and seat dates, and indicate if there was any prior inlay or onlay (if so, need date of prior placement).
D2792	Crown, Full Cast Nobel Metal	Predetermination Recommended	Dental Necessity	Preoperative x-rays, a narrative describing existing restorations and areas of decay/defects, prep and seat dates, and indicate if there was any prior inlay or onlay (if so, need date of prior placement).
D2794	Crown - titanium	Predetermination Recommended	Dental Necessity	Preoperative x-rays, a narrative describing existing restorations and areas of decay/defects, prep and seat dates, and indicate if there was any prior inlay or onlay (if so, need date of prior placement).

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
D2950	Core buildup, including pins	Predetermination Recommended	Dental Necessity	Preoperative x-rays, narrative describing existing restorations and areas of decay or defect. Indicate if there was any prior inlay, onlay, crown, or veneer - if so, need date of prior placement.
D2952	Post and core in addition to crown, indirectly fabricated	Predetermination Recommended	Dental Necessity	Preoperative x-rays, narrative describing existing restorations and areas of decay or defect. Indicate if there was any prior inlay, onlay, crown, or veneer - if so, need date of prior placement.
D2954	Prefabricated post and core in addition to crown	Predetermination Recommended	Dental Necessity	Preoperative x-rays, narrative describing existing restorations and areas of decay or defect. Indicate if there was any prior inlay, onlay, crown, or veneer - if so, need date of prior placement.
D2960	Labial Veneer (resin laminate), Chairside	Predetermination Recommended	Dental Necessity	Preoperative x-rays, a narrative describing existing restorations and areas of decay/defects, prep and seat dates, and indicate if there was a prior veneer (if so, need date of prior placement).
D2961	Labial veneer (resin laminate) - laboratory	Predetermination Recommended	Dental Necessity	Preoperative x-rays, a narrative describing existing restorations and areas of decay/defects, prep and seat dates, and indicate if there was a prior veneer (if so, need date of prior placement).

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
D2962	Labial veneer (porcelain laminate) - laboratory	Predetermination Recommended	Dental Necessity	Preoperative x-rays, a narrative describing existing restorations and areas of decay/defects, prep and seat dates, and indicate if there was a prior veneer (if so, need date of prior placement).
D2971	Additional procedures to construct new crown under existing partial denture framework	Predetermination Recommended	Dental Necessity	Narrative and/or chart notes.
D2980	Crown repair necessitated by restorative material failure	Predetermination Recommended	Dental Necessity	Chart notes or narrative (including when crown was cemented) specifically describing the procedure or procedures done to repair the crown.
D2981	Inlay repair necessitated by restorative material failure	Predetermination Recommended	Dental Necessity	Chart notes or narrative (including when inlay was cemented) specifically describing the procedure or procedures done to repair the inlay.
D2982	Onlay repair necessitated by restorative material failure	Predetermination Recommended	Dental Necessity	Chart notes or narrative (including when onlay was cemented) specifically describing the procedure or procedures done to repair the onlay.
D2983	Veneer repair necessitated by restorative material failure	Predetermination Recommended	Dental Necessity	Chart notes or narrative (including when veneer was cemented) specifically describing the procedure or procedures done to repair the veneer.
D2999	Unspecified restorative procedure, by report	Predetermination Recommended	Dental Necessity	Chart notes and/or narrative describing procedure performed.
D3310	Endodontic therapy, anterior tooth (excluding final restoration)	Predetermination Recommended	Dental Necessity	Xrays; Narrative
D3320	Endodontic therapy, bicuspid tooth (excluding final restoration)	Predetermination Recommended	Dental Necessity	Xrays; Narrative
D3330	Endodontic therapy, molar (excluding final restoration)	Predetermination Recommended	Dental Necessity	Xrays; Narrative

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
D3331	Treatment of root canal obstruction; non-surgical access	Predetermination Recommended	Dental Necessity	Narrative and/or chart notes
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	Predetermination Recommended	Dental Necessity	Narrative and/or chart notes
D3333	Internal root repair of perforation defects	Predetermination Recommended	Dental Necessity	Narrative and/or chart notes
D3346	Retreatment of previous root canal therapy - anterior	Predetermination Recommended	Dental Necessity	Date of initial root canal. If retreatment done less than 12 months from the initial root canal, need chart notes, x-rays and a narrative for review.
D3347	Retreatment of previous root canal therapy - bicuspid	Predetermination Recommended	Dental Necessity	Date of initial root canal. If retreatment done less than 12 months from the initial root canal, need chart notes, x-rays and a narrative for review.
D3348	Retreatment of previous root canal therapy - molar	Predetermination Recommended	Dental Necessity	Date of initial root canal. If retreatment done less than 12 months from the initial root canal, need chart notes, x-rays and a narrative for review.
D3351	Apexification/recalcification - initial visit (apical closure/calcific repair of perforations, root resorption, etc.)	Predetermination Recommended	Dental Necessity	Narrative
D3352	Apexification/recalcification - interim medication replacement	Predetermination Recommended	Dental Necessity	Narrative
D3353	Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.)	Predetermination Recommended	Dental Necessity	Narrative
D3355	Pulpal regeneration - initial visit	Predetermination Recommended	Dental Necessity	Narrative and/or chart notes
D3356	Pulpal regeneration - interim medication replacement	Predetermination Recommended	Dental Necessity	Narrative and/or chart notes
D3357	Pulpal regeneration - completion of treatment	Predetermination Recommended	Dental Necessity	Narrative and/or chart notes
D3410	Apicoectomy - anterior	Predetermination Recommended	Dental Necessity	Narrative
D3421	Apicoectomy - bicuspid (first root)	Predetermination Recommended	Dental Necessity	Narrative

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
D3425	Apicoectomy - molar (first root)	Predetermination Recommended	Dental Necessity	Narrative
D3426	Apicoectomy (each additional root)	Predetermination Recommended	Dental Necessity	Narrative
D3427	Periradicular surgery without apicoectomy	Predetermination Recommended	Dental Necessity	X-ray(s), narrative and rationale for the proposed surgery.
D3430	Retrograde filling - per root	Predetermination Recommended	Dental Necessity	Narrative
D3431	biologic materials to aid in soft and osseous tissue regeneration in conjunction with periradicular surgery	Predetermination Recommended	Dental Necessity	Narrative
D3460	endodontic endosseous implant	Predetermination Recommended	Dental Necessity	Narrative
D3470	intentional re-implantation (including necessary splinting)	Predetermination Recommended	Dental Necessity	X-rays and chart notes.
D3471	Surgical repair of root resorption – anterior For surgery on root of anterior teeth. Does not include placement of restoration.	Predetermination Recommended	Dental Necessity	X-ray(s), narrative and rationale for the proposed surgery.
D3472	Surgical repair of root resorption – premolar For surgery on root of premolar tooth. Does not include placement of restoration.	Predetermination Recommended	Dental Necessity	X-ray(s), narrative and rationale for the proposed surgery.
D3473	Surgical repair of root resorption – molar For surgery on root of molar tooth. Does not include placement of restoration.	Predetermination Recommended	Dental Necessity	X-ray(s), narrative and rationale for the proposed surgery.
D3501	Surgical repair of root surface without apicoectomy or repair of root resorption – anterior Exposure of root surface followed by observation and surgical closure of the exposed area. Not to be used for or in conjunction with apicoectomy or repair of root resorption.	Predetermination Recommended	Dental Necessity	X-ray(s), narrative and rationale for the proposed surgery.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
D3502	Surgical repair of root surface without apicoectomy or repair of root resorption – premolar Exposure of root surface followed by observation and surgical closure of the exposed area. Not to be used for or in conjunction with apicoectomy or repair of root resorption.	Predetermination Recommended	Dental Necessity	X-ray(s), narrative and rationale for the proposed surgery.
D3503	Surgical repair of root surface w/o apicoectomy or repair of root resorption - molar exposure of root surface followed by observation and surgical closure of the exposed area	Predetermination Recommended	Medical Necessity	X-ray(s), narrative and rationale for the proposed surgery.
D3910	surgical procedure for isolation of tooth with rubber dam	Predetermination Recommended	Dental Necessity	Narrative and pre-operative x-ray (that shows lack of tooth structure that would justify surgical procedure to allow rubber dam)
D3920	hemisection (including any root removal), not including root canal therapy	Predetermination Recommended	Dental Necessity	Narrative
D3950	canal preparation and fitting of preformed dowel or post	Predetermination Recommended	Dental Necessity	X-ray and chart notes required if billed in conjunction with D2952, D2953, D2954 or D2957 on the same tooth, by the same provider, on the same day.
D3999	unspecified endodontic procedure, by report	Predetermination Recommended	Dental Necessity	Chart notes and/or narrative describing procedure performed.
D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant	Predetermination Recommended	Dental Necessity	Periodontal charting, Narrative, and photo (if available
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant	Predetermination Recommended	Dental Necessity	Periodontal charting Preoperative x-ray - only if billed in conjunction with impacted wisdom teeth.
D4212	Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth	Predetermination Recommended	Dental Necessity	Periapical x-ray Periodontal charting Photo (if available)

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
D4230	Anatomical crown exposure - four or more contiguous teeth per quadrant	Predetermination Recommended	Dental Necessity	Periodontal charting and periapical x-rays
D4231	Anatomical crown exposure - one to three teeth per quadrant	Predetermination Recommended	Dental Necessity	Periodontal charting and periapical x-rays
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant	Predetermination Recommended	Dental Necessity	Periodontal charting, Narrative, and photo (if available
D4241	Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant	Predetermination Recommended	Dental Necessity	Periodontal charting, Narrative, and photo (if available
D4245	Apically positioned flap	Predetermination Recommended	Dental Necessity	Periodontal charting, Narrative, and photo (if available
D4249	Clinical crown lengthening - hard tissue	Predetermination Recommended	Dental Necessity	Periapical x-ray Periodontal charting Photo (if available)
D4260	Osseous surgery (including elevation of a full thickness flap and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant	Predetermination Recommended	Dental Necessity	Periodontal charting, Narrative, and photo (if available)
D4261	Osseous surgery (including elevation of a full thickness flap and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant	Predetermination Recommended	Dental Necessity	Periodontal charting, Narrative, and photo (if available)
D4263	Bone replacement graft - retained natural tooth -first site in quadrant	Predetermination Recommended	Dental Necessity	Periapical x-ray, periodontal charting and/or narrative including pocket depth and osseous defects
D4264	Bone replacement graft - retained natural tooth -each additional site in quadrant	Predetermination Recommended	Dental Necessity	Periapical x-ray, periodontal charting and/or narrative including pocket depth and osseous defects
D4265	Biologic materials to aid in soft and osseous tissue regeneration	Predetermination Recommended	Dental Necessity	Name and type of biologic material used.
D4266	Guided tissue regeneration - resorbable barrier, per site	Predetermination Recommended	Dental Necessity	Periapical x-ray, periodontal charting and/or narrative including pocket depth and osseous defects

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
D4267	Guided tissue regeneration - non-resorbable barrier, per site (includes membrane removal)	Predetermination Recommended	Dental Necessity	Periapical x-ray, periodontal charting and/or narrative including pocket depth and osseous defects
D4268	Surgical revision procedure, per tooth	Predetermination Recommended	Dental Necessity	Perio charting, PA x-rays, and a narrative detailing the previously provided surgical procedure and the need for additional procedure(s).
D4270	Pedicle soft tissue graft procedure	Predetermination Recommended	Dental Necessity	Periodontal charting and/or; Narrative and/or; Photograph
D4273	Autogenous connective tissue graft procedure (including donor and recipient surgical sites) first tooth, implant or edentulous tooth position	Predetermination Recommended	Dental Necessity	Periodontal charting and/or; Narrative and/or; Photograph
D4274	Mesial/distal wedge procedure, single tooth (when not performed in conjunction with surgical procedures in the same anatomical area)	Predetermination Recommended	Dental Necessity	Narrative and rational for service. Chart notes or op report detailing procedure preformed.
D4275	Non-autogenous connective tissue graft (including recipient site and donor material) first tooth, implant, or edentulous tooth position in graft	Predetermination Recommended	Dental Necessity	Periodontal charting and/or; Narrative and/or; Photograph
D4276	Combined connective tissue and double pedicle graft, per tooth	Predetermination Recommended	Dental Necessity	Periodontal charting and/or; Narrative and/or; Photograph
D4277	Free soft tissue graft procedure (including recipient and donor surgical sites) first tooth, implant, or edentulous tooth position in graft	Predetermination Recommended	Dental Necessity	Periodontal charting and/or; Narrative and/or; Photograph
D4278	Free soft tissue graft procedure (including recipient and donor surgical sites) each additional contiguous tooth, implant, or edentulous tooth position in same graft site	Predetermination Recommended	Dental Necessity	Periodontal charting and/or; Narrative and/or; Photograph

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
D4283	Autogenous connective tissue graft procedure (including donor and recipient surgical sites) - each additional contiguous tooth, implant or edentulous tooth position in same graft site	Predetermination Recommended	Dental Necessity	Periodontal charting and/or; Narrative and/or; Photograph
D4285	Non-autogenous connective tissue graft procedure (including recipient surgical site and donor material) - each additional contiguous tooth, implant or edentulous tooth position in same graft site	Predetermination Recommended	Dental Necessity	Periodontal charting and/or; Narrative and/or; Photograph
D4320	Provisional splinting - intracoronal	Predetermination Recommended	Dental Necessity	Periodontal charting, x-ray, and chart notes or narrative
D4321	Provisional splinting - extracoronal	Predetermination Recommended	Dental Necessity	Periodontal charting, x-ray, and chart notes or narrative
D4381	Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth	Predetermination Recommended	Dental Necessity	Periodontal charting Name of material used (Arestin, Atridox, or PerioChip, etc.) Tooth numbers
D4999	Unspecified periodontal procedure, by report	Predetermination Recommended	Dental Necessity	Chart notes, narrative, periodontal charting, pre-operative x-ray, or photo may be required.
D5850	Tissue conditioning, maxillary	Predetermination Recommended	Dental Necessity	Narrative
D5851	Tissue conditioning, mandibular	Predetermination Recommended	Dental Necessity	Narrative
D5899	Unspecified removable prosthodontic procedure, by report	Predetermination Recommended	Dental Necessity	Chart notes and a narrative
D5911	Facial moulage (sectional)	Predetermination Recommended	Medical or Dental Service	Narrative
D5912	Facial moulage (complete)	Predetermination Recommended	Medical or Dental Service	Narrative
D5913	Nasal prosthesis	Predetermination Recommended	Medical or Dental Service	Narrative
D5914	Auricular prosthesis	Predetermination Recommended	Medical or Dental Service	Narrative
D5915	Orbital prosthesis	Predetermination Recommended	Medical or Dental Service	Narrative
D5916	Ocular prosthesis	Predetermination Recommended	Medical or Dental Service	Narrative
D5919	Facial prosthesis	Predetermination Recommended	Medical or Dental Service	Narrative
D5922	Nasal septal prosthesis	Predetermination Recommended	Medical or Dental Service	Narrative
D5923	Ocular prosthesis, interim	Predetermination Recommended	Medical or Dental Service	Narrative

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
D5924	Cranial prosthesis	Predetermination Recommended	Medical or Dental Service	Narrative
D5925	Facial augmentation implant prosthesis	Predetermination Recommended	Medical or Dental Service	Narrative
D5926	Nasal prosthesis, replacement	Predetermination Recommended	Medical or Dental Service	Narrative
D5927	Auricular prosthesis, replacement	Predetermination Recommended	Medical or Dental Service	Narrative
D5928	Orbital prosthesis, replacement	Predetermination Recommended	Medical or Dental Service	Narrative
D5929	facial prosthesis, replacement	Predetermination Recommended	Medical or Dental Service	Narrative
D5931	Obturator prosthesis, surgical	Predetermination Recommended	Medical or Dental Service	Narrative
D5932	Obturator prosthesis, definitive	Predetermination Recommended	Medical or Dental Service	Narrative
D5933	Obturator prosthesis, modification	Predetermination Recommended	Medical or Dental Service	Narrative
D5934	Mandibular resection prosthesis with guide flange	Predetermination Recommended	Medical or Dental Service	Narrative
D5935	Mandibular resection prosthesis without guide flange	Predetermination Recommended	Medical or Dental Service	Narrative
D5936	Obturator prosthesis, interim	Predetermination Recommended	Medical or Dental Service	Narrative
D5937	Trismus appliance (not for TMD treatment)	Predetermination Recommended	Medical or Dental Service	Narrative
D5951	Feeding aid	Predetermination Recommended	Medical or Dental Service	Narrative
D5952	Speech aid prosthesis, pediatric	Predetermination Recommended	Medical or Dental Service	Narrative
D5953	Speech aid prosthesis, adult	Predetermination Recommended	Medical or Dental Service	Narrative
D5954	Palatal augmentation prosthesis	Predetermination Recommended	Medical or Dental Service	Narrative
D5955	Palatal lift prosthesis, definitive	Predetermination Recommended	Medical or Dental Service	Narrative
D5958	Palatal lift prosthesis, interim	Predetermination Recommended	Medical or Dental Service	Narrative
D5959	Palatal lift prosthesis, modification	Predetermination Recommended	Medical or Dental Service	Narrative
D5960	Speech aid prosthesis, modification	Predetermination Recommended	Medical or Dental Service	Narrative
D5983	Radiation carrier	Predetermination Recommended	Medical or Dental Service	Narrative
D5984	Radiation shield	Predetermination Recommended	Medical or Dental Service	Narrative
D5985	Radiation cone locator	Predetermination Recommended	Medical or Dental Service	Narrative
D5986	Fluoride gel carrier	Predetermination Recommended	Medical or Dental Service	Narrative or chart notes if related to cancer or other medical necessary treatment.
D5987	Commissure splint	Predetermination Recommended	Medical or Dental Service	Narrative
D5988	Surgical splint	Predetermination Recommended	Medical or Dental Service	Narrative and chart notes/office records
D5991	Vesiculobullous disease medicament carrier	Predetermination Recommended	Medical or Dental Service	Narrative

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D5992	Adjust maxillofacial prosthetic appliance, by report	Predetermination Recommended	Medical or Dental Service	Narrative and rationale for the proposed treatment
D5993	Maintenance and cleaning of a maxillofacial prosthesis (extra- or intra-oral) other than required adjustments, by report	Predetermination Recommended	Dental Necessity	Narrative
D5994	Periodontal medicament carrier with peripheral seal - laboratory processed	Predetermination Recommended	Dental Necessity	Periodontal charting, narrative, and/or photographs showing recession and status of attached gingiva to demonstrate the necessity of this service.
D5995	Periodontal Medicament carrier with peripheral seal - laboratory processed - maxillary a custom fabricated, laboratory processed carrier for the maxillary arch that covers the teeth and alveolar mucosa. Used as a vehicle to deliver prescribed medicaments for sustained contact with the gingiva, alveolar mucosa and into the periodontal sulcus or pocket	Predetermination Recommended	Dental Necessity	Periodontal charting, narrative, and/or photographs showing recession and status of attached gingiva to demonstrate the necessity of this service.
D5996	Periodontal medicament carrier with peripheral seal - laboratory processed - mandibular a custom fabricated, laboratory processes carrier for the mandibular arch that covers the teeth and alveolar mucosa. Used as a vehicle to deliver prescribed medicaments for sustained contact with the gingiva, alveolar mucosa, and into the periodontal sulcus or pocket	Predetermination Recommended	Dental Necessity	Periodontal charting, narrative, and/or photographs showing recession and status of attached gingiva to demonstrate the necessity of this service.
D5999	Unspecified maxillofacial prosthesis, by report	Predetermination Recommended	Dental Necessity	Chart notes and a narrative

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
D6010	Surgical placement of implant body: endosteal implant	Predetermination Recommended	Dental Necessity	Preoperative full mouth x-rays, All missing teeth, Periodontal charting, Chart notes, Prognosis of implant, Full treatment plan for patient
D6013	Surgical placement of mini implant	Predetermination Recommended	Dental Necessity	Periodontal charting, 5 year prognosis, Preoperative x-rays, All missing teeth
D6040	Surgical placement: eposteal implant	Predetermination Recommended	Dental Necessity	Preoperative x-rays, perio charting, chart notes, prognosis of implant, full treatment plan for patient
D6050	Surgical placement: transosteal implant	Predetermination Recommended	Dental Necessity	Preoperative x-rays, perio charting, chart notes, prognosis of implant, full treatment plan for patient
D6055	Connecting bar - implant supported or abutment supported	Predetermination Recommended	Dental Necessity	Narrative
D6058	Abutment supported porcelain/ceramic crown	Predetermination Recommended	Dental Necessity	X-ray(s), narrative, all missing teeth, and indicate if initial placement or provide the date of the prior placement.
D6059	Abutment supported porcelain fused to metal crown (high noble metal)	Predetermination Recommended	Dental Necessity	X-ray(s), narrative, all missing teeth, and indicate if initial placement or provide the date of the prior placement.
D6060	Abutment supported porcelain fused to metal crown (predominantly base metal)	Predetermination Recommended	Dental Necessity	X-ray(s), narrative, all missing teeth, and indicate if initial placement or provide the date of the prior placement.
D6061	Abutment supported porcelain fused to metal crown (noble metal)	Predetermination Recommended	Dental Necessity	X-ray(s), narrative, all missing teeth, and indicate if initial placement or provide the date of the prior placement.
D6062	Abutment supported cast metal crown (high noble metal)	Predetermination Recommended	Dental Necessity	X-rays, chart notes, periodontal status, list of all missing teeth, list of all existing bridgework, partials and dentures.
D6063	Abutment supported cast metal crown (predominantly base metal)	Predetermination Recommended	Dental Necessity	X-rays, chart notes, periodontal status, list of all missing teeth, list of all existing bridgework, partials and dentures.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
D6064	Abutment supported cast metal crown (noble metal)	Predetermination Recommended	Dental Necessity	X-rays, chart notes, periodontal status, list of all missing teeth, list of all existing bridgework, partials and dentures.
D6065	Implant supported porcelain/ceramic crown	Predetermination Recommended	Dental Necessity	X-rays, chart notes, periodontal status, list of all missing teeth, list of all existing bridgework, partials and dentures.
D6066	Implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal)	Predetermination Recommended	Dental Necessity	X-rays, chart notes, periodontal status, list of all missing teeth, list of all existing bridgework, partials and dentures.
D6067	Implant supported metal crown (titanium, titanium alloy, high noble metal)	Predetermination Recommended	Dental Necessity	X-rays, chart notes, periodontal status, list of all missing teeth, list of all existing bridgework, partials and dentures.
D6081	Scaling and debridement in the presence of inflammation or mucositis of a single implant, including cleaning of the implant surfaces, without flap entry and closure	Predetermination Recommended	Dental Necessity	Periodontal charting and/or; Narrative and/or; Photograph
D6082	Implant supported crown porcelain fused to predominantly base alloys	Predetermination Recommended	Dental Necessity	X-rays, chart notes, periodontal status, list of all missing teeth, list of all existing bridgework, partials and dentures.
D6083	Implant supported crown porcelain fused to noble alloys	Predetermination Recommended	Dental Necessity	X-rays, chart notes, periodontal status, list of all missing teeth, list of all existing bridgework, partials and dentures.
D6084	Implant supported crown porcelain fused to titanium and titanium alloys	Predetermination Recommended	Dental Necessity	X-rays, chart notes, periodontal status, list of all missing teeth, list of all existing bridgework, partials and dentures.
D6085	Provisional implant crown	Predetermination Recommended	Dental Necessity	Narrative

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
D6086	Implant supported crown predominantly base alloys	Predetermination Recommended	Dental Necessity	X-rays, chart notes, periodontal status, list of all missing teeth, list of all existing bridgework, partials and dentures.
D6087	Implant supported crown noble alloys	Predetermination Recommended	Dental Necessity	X-rays, chart notes, periodontal status, list of all missing teeth, list of all existing bridgework, partials and dentures.
D6088	Implant supported crown titanium and titanium alloys	Predetermination Recommended	Dental Necessity	X-rays, chart notes, periodontal status, list of all missing teeth, list of all existing bridgework, partials and dentures.
D6089	ACCESSING AND RETORQUING LOOSE IMPLANT SCREW - PER SCREW	Predetermination Recommended	Dental Necessity	Narrative
D6090	Repair implant supported prosthesis, by report	Predetermination Recommended	Dental Necessity	Chart notes or narrative specifically describing the repair or replacement of any part of the implant supported prosthesis.
D6091	Replacement of semi-precision or precision attachment (male or female component) of implant/abutment supported prosthesis, per attachment	Predetermination Recommended	Dental Necessity	N/A
D6094	Abutment supported crown (titanium)	Predetermination Recommended	Dental Necessity	X-rays, chart notes, periodontal status, list of all missing teeth, list of all existing bridgework, partials and dentures.
D6095	Repair implant abutment, by report	Predetermination Recommended	Dental Necessity	Narrative
D6096	Remove broken implant retaining screw	Predetermination Recommended	Dental Necessity	Narrative
D6097	Abutment supported crown porcelain fused to titanium and titanium alloy	Predetermination Recommended	Dental Necessity	X-rays, chart notes, periodontal status, list of all missing teeth, list of all existing bridgework, partials and dentures.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
D6100	Implant removal, by report	Predetermination Recommended	Dental Necessity	Narrative (A panoramic x-ray or periapical x-ray may be required if dental consultant review is required)
D6101	Debridement of a peri-implant defect or defects surrounding a single implant, and surface cleaning of the exposed implant surfaces, including flap entry and closure	Predetermination Recommended	Dental Necessity	Narrative and/or chart notes describing the necessity for this service
D6102	Debridement and osseous contouring of a peri-implant defect or defects surrounding a single implant and includes surface cleaning of the exposed implant surfaces, including flap entry and closure	Predetermination Recommended	Dental Necessity	Narrative and/or chart notes describing the necessity for this service
D6103	Bone graft for repair of peri-implant defect - does not include flap entry and closure	Predetermination Recommended	Dental Necessity	Periapical x-rays and periodontal charting
D6104	Bone graft at time of implant placement	Predetermination Recommended	Dental Necessity	Periapical x-ray and detailed narrative including diagnosis if applicable.
D6119	Implant/abutment supported interim fixed denture for edentulous arch - maxillary	Predetermination Recommended	Dental Necessity	Narrative
D6123	Implant supported retainer for metal fpd titanium and titanium alloys	Predetermination Recommended	Dental Necessity	Narrative
D6190	Radiographic/surgical implant index, by report	Predetermination Recommended	Dental Necessity	Narrative
D6194	Abutment supported retainer crown for FPD (titanium)	Predetermination Recommended	Dental Necessity	Narrative
D6199	Unspecified implant procedure, by report	Predetermination Recommended	Dental Necessity	Chart notes and a narrative
D6205	Pontic - indirect resin based composite	Predetermination Recommended	Dental Necessity	Narrative

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
D6210	Pontic - cast high noble metal	Predetermination Recommended	Dental Necessity	X-rays, list of all missing teeth in both arches, list of all existing bridgework and/or dentures in both arches, indicate if there was any prior bridge or denture that this new bridge is replacing (if so, need date of prior placement), prep and seat dates
D6211	Pontic - cast predominantly base metal	Predetermination Recommended	Dental Necessity	X-rays, list of all missing teeth in both arches, list of all existing bridgework and/or dentures in both arches, indicate if there was any prior bridge or denture that this new bridge is replacing (if so, need date of prior placement), prep and seat dates
D6212	Pontic - cast noble metal	Predetermination Recommended	Dental Necessity	X-rays, list of all missing teeth in both arches, list of all existing bridgework and/or dentures in both arches, indicate if there was any prior bridge or denture that this new bridge is replacing (if so, need date of prior placement), prep and seat dates
D6214	Pontic - titanium	Predetermination Recommended	Dental Necessity	X-rays, list of all missing teeth in both arches, list of all existing bridgework and/or dentures in both arches, indicate if there was any prior bridge or denture that this new bridge is replacing (if so, need date of prior placement), prep and seat dates

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
D6240	Pontic - porcelain fused to high noble metal	Predetermination Recommended	Dental Necessity	X-rays, list of all missing teeth in both arches, list of all existing bridgework and/or dentures in both arches, indicate if there was any prior bridge or denture that this new bridge is replacing (if so, need date of prior placement), prep and seat dates
D6241	Pontic - porcelain fused to predominantly base metal	Predetermination Recommended	Dental Necessity	X-rays, list of all missing teeth in both arches, list of all existing bridgework and/or dentures in both arches, indicate if there was any prior bridge or denture that this new bridge is replacing (if so, need date of prior placement), prep and seat dates
D6242	Pontic - porcelain fused to noble metal	Predetermination Recommended	Dental Necessity	X-rays, list of all missing teeth in both arches, list of all existing bridgework and/or dentures in both arches, indicate if there was any prior bridge or denture that this new bridge is replacing (if so, need date of prior placement), prep and seat dates
D6243	Pontic porcelain fused to titanium and titanium alloys	Predetermination Recommended	Dental Necessity	X-rays, chart notes, periodontal status, list of all missing teeth, list of all existing bridgework, partials and dentures.
D6245	Pontic - porcelain/ceramic	Predetermination Recommended	Dental Necessity	X-rays, list of all missing teeth in both arches, list of all existing bridgework and/or dentures in both arches, indicate if there was any prior bridge or denture that this new bridge is replacing (if so, need date of prior placement), prep and seat dates

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
D6250	Pontic - resin with high noble metal	Predetermination Recommended	Dental Necessity	X-rays, list of all missing teeth in both arches, list of all existing bridgework and/or dentures in both arches, indicate if there was any prior bridge or denture that this new bridge is replacing (if so, need date of prior placement), prep and seat dates
D6251	Pontic - resin with predominantly base metal	Predetermination Recommended	Dental Necessity	X-rays, list of all missing teeth in both arches, list of all existing bridgework and/or dentures in both arches, indicate if there was any prior bridge or denture that this new bridge is replacing (if so, need date of prior placement), prep and seat dates
D6252	Pontic - resin with noble metal	Predetermination Recommended	Dental Necessity	X-rays, list of all missing teeth in both arches, list of all existing bridgework and/or dentures in both arches, indicate if there was any prior bridge or denture that this new bridge is replacing (if so, need date of prior placement), prep and seat dates
D6545	Retainer - cast metal for resin bonded fixed prosthesis	Predetermination Recommended	Dental Necessity	X-rays, list of all missing teeth in both arches, list of all existing bridgework and/or dentures in both arches, indicate if there was any prior bridge or denture that this new bridge is replacing (if so, need date of prior placement), prep and seat dates

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
D6548	Retainer - porcelain/ceramic for resin bonded fixed prosthesis	Predetermination Recommended	Dental Necessity	X-rays, list of all missing teeth in both arches, list of all existing bridgework and/or dentures in both arches, indicate if there was any prior bridge or denture that this new bridge is replacing (if so, need date of prior placement), prep and seat dates
D6600	Retainer inlay - porcelain/ceramic, two surfaces	Predetermination Recommended	Dental Necessity	Preoperative x-rays, a narrative describing existing restorations and areas of decay/defects, surfaces, prep and seat dates, and indicate if there was any prior inlay or onlay (if so, need date of prior placement)
D6601	Retainer inlay - porcelain/ceramic, three or more surfaces	Predetermination Recommended	Dental Necessity	Preoperative x-rays, a narrative describing existing restorations and areas of decay/defects, surfaces, prep and seat dates, and indicate if there was any prior inlay or onlay (if so, need date of prior placement)
D6602	Retainer inlay - cast high noble metal, two surfaces	Predetermination Recommended	Dental Necessity	Preoperative x-rays, a narrative describing existing restorations and areas of decay/defects, surfaces, prep and seat dates, and indicate if there was any prior inlay or onlay (if so, need date of prior placement)
D6603	Retainer inlay - cast high noble metal, three or more surfaces	Predetermination Recommended	Dental Necessity	Preoperative x-rays, a narrative describing existing restorations and areas of decay/defects, surfaces, prep and seat dates, and indicate if there was any prior inlay or onlay (if so, need date of prior placement)

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
D6604	Retainer inlay - cast predominantly base metal, two surfaces	Predetermination Recommended	Dental Necessity	Preoperative x-rays, a narrative describing existing restorations and areas of decay/defects, surfaces, prep and seat dates, and indicate if there was any prior inlay or onlay (if so, need date of prior placement)
D6605	Retainer inlay - cast predominantly base metal, three or more surfaces	Predetermination Recommended	Dental Necessity	Preoperative x-rays, a narrative describing existing restorations and areas of decay/defects, surfaces, prep and seat dates, and indicate if there was any prior inlay or onlay (if so, need date of prior placement)
D6606	Retainer inlay - cast noble metal, two surfaces	Predetermination Recommended	Dental Necessity	Preoperative x-rays, a narrative describing existing restorations and areas of decay/defects, surfaces, prep and seat dates, and indicate if there was any prior inlay or onlay (if so, need date of prior placement)
D6607	Retainer inlay - cast noble metal, three or more surfaces	Predetermination Recommended	Dental Necessity	Preoperative x-rays, a narrative describing existing restorations and areas of decay/defects, surfaces, prep and seat dates, and indicate if there was any prior inlay or onlay (if so, need date of prior placement)
D6608	Retainer onlay - porcelain/ceramic, two surfaces	Predetermination Recommended	Dental Necessity	Preoperative x-rays, a narrative describing existing restorations and areas of decay/defects, surfaces, prep and seat dates, and indicate if there was any prior inlay or onlay (if so, need date of prior placement)

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
D6609	Retainer onlay - porcelain/ceramic, three or more surfaces	Predetermination Recommended	Dental Necessity	Preoperative x-rays, a narrative describing existing restorations and areas of decay/defects, surfaces, prep and seat dates, and indicate if there was any prior inlay or onlay (if so, need date of prior placement)
D6610	Retainer onlay - cast high noble metal, two surfaces	Predetermination Recommended	Dental Necessity	Preoperative x-rays, a narrative describing existing restorations and areas of decay/defects, surfaces, prep and seat dates, and indicate if there was any prior inlay or onlay (if so, need date of prior placement)
D6611	Retainer onlay - cast high noble metal, three or more surfaces	Predetermination Recommended	Dental Necessity	Preoperative x-rays, a narrative describing existing restorations and areas of decay/defects, surfaces, prep and seat dates, and indicate if there was any prior inlay or onlay (if so, need date of prior placement)
D6612	Retainer onlay - cast predominantly base metal, two surfaces	Predetermination Recommended	Dental Necessity	Preoperative x-rays, a narrative describing existing restorations and areas of decay/defects, surfaces, prep and seat dates, and indicate if there was any prior inlay or onlay (if so, need date of prior placement)
D6613	Retainer onlay - cast predominantly base metal, three or more surfaces	Predetermination Recommended	Dental Necessity	Preoperative x-rays, a narrative describing existing restorations and areas of decay/defects, surfaces, prep and seat dates, and indicate if there was any prior inlay or onlay (if so, need date of prior placement)

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
D6614	Retainer onlay - cast noble metal, two surfaces	Predetermination Recommended	Dental Necessity	Preoperative x-rays, a narrative describing existing restorations and areas of decay/defects, surfaces, prep and seat dates, and indicate if there was any prior inlay or onlay (if so, need date of prior placement)
D6615	Retainer onlay - cast noble metal, three or more surfaces	Predetermination Recommended	Dental Necessity	Preoperative x-rays, a narrative describing existing restorations and areas of decay/defects, surfaces, prep and seat dates, and indicate if there was any prior inlay or onlay (if so, need date of prior placement)
D6634	Retainer onlay - titanium	Predetermination Recommended	Dental Necessity	Preoperative x-rays, a narrative describing existing restorations and areas of decay/defects, surfaces, prep and seat dates, and indicate if there was any prior inlay or onlay (if so, need date of prior placement)
D6720	Retainer crown - resin with high noble metal	Predetermination Recommended	Dental Necessity	X-rays, list of all missing teeth in both arches, list of all existing bridgework and/or dentures in both arches, indicate if there was any prior bridge or denture that this new bridge is replacing (if so, need date of prior placement), prep and seat dates
D6721	Retainer crown - resin with predominantly base metal	Predetermination Recommended	Dental Necessity	X-rays, list of all missing teeth in both arches, list of all existing bridgework and/or dentures in both arches, indicate if there was any prior bridge or denture that this new bridge is replacing (if so, need date of prior placement), prep and seat dates

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D6722	Retainer crown - resin with noble metal	Predetermination Recommended	Dental Necessity	X-rays, list of all missing teeth in both arches, list of all existing bridgework and/or dentures in both arches, indicate if there was any prior bridge or denture that this new bridge is replacing (if so, need date of prior placement), prep and seat dates
D6740	Retainer crown - porcelain/ceramic	Predetermination Recommended	Dental Necessity	Preoperative x-rays, a narrative describing existing restorations and areas of decay/defects, prep and seat dates, and indicate if there was any prior inlay or onlay (if so, need date of prior placement).
D6750	Retainer crown - porcelain fused to high noble metal	Predetermination Recommended	Dental Necessity	X-rays, list of all missing teeth in both arches, list of all existing bridgework and/or dentures in both arches, indicate if there was any prior bridge or denture that this new bridge is replacing (if so, need date of prior placement), prep and seat dates
D6751	Retainer crown - porcelain fused to predominantly base metal	Predetermination Recommended	Dental Necessity	X-rays, list of all missing teeth in both arches, list of all existing bridgework and/or dentures in both arches, indicate if there was any prior bridge or denture that this new bridge is replacing (if so, need date of prior placement), prep and seat dates
D6752	Retainer crown - porcelain fused to noble metal	Predetermination Recommended	Dental Necessity	X-rays, list of all missing teeth in both arches, list of all existing bridgework and/or dentures in both arches, indicate if there was any prior bridge or denture that this new bridge is replacing (if so, need date of prior placement), prep and seat dates

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
D6753	RETAINER CROWN PORCELAIN FUSED TO TITANIUM AND TITANIUM ALLOYS	Predetermination Recommended	Dental Necessity	X-rays, chart notes, periodontal status, list of all missing teeth, list of all existing bridgework, partials and dentures.
D6780	Retainer crown - 3/4 cast high noble metal	Predetermination Recommended	Dental Necessity	X-rays, list of all missing teeth in both arches, list of all existing bridgework and/or dentures in both arches, indicate if there was any prior bridge or denture that this new bridge is replacing (if so, need date of prior placement), prep and seat dates
D6781	Retainer crown - 3/4 cast predominantly base metal	Predetermination Recommended	Dental Necessity	X-rays, list of all missing teeth in both arches, list of all existing bridgework and/or dentures in both arches, indicate if there was any prior bridge or denture that this new bridge is replacing (if so, need date of prior placement), prep and seat dates
D6782	Retainer crown - 3/4 cast noble metal	Predetermination Recommended	Dental Necessity	X-rays, list of all missing teeth in both arches, list of all existing bridgework and/or dentures in both arches, indicate if there was any prior bridge or denture that this new bridge is replacing (if so, need date of prior placement), prep and seat dates
D6783	Retainer crown - 3/4 porcelain/ceramic	Predetermination Recommended	Dental Necessity	X-rays, list of all missing teeth in both arches, list of all existing bridgework and/or dentures in both arches, indicate if there was any prior bridge or denture that this new bridge is replacing (if so, need date of prior placement), prep and seat dates

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
D6784	Retainer crown 3/4 titanium and titanium alloys	Predetermination Recommended	Medical Necessity	X-rays, chart notes, periodontal status, list of all missing teeth, list of all existing bridgework, partials and dentures.
D6790	Retainer crown - full cast high noble metal	Predetermination Recommended	Dental Necessity	X-rays, list of all missing teeth in both arches, list of all existing bridgework and/or dentures in both arches, indicate if there was any prior bridge or denture that this new bridge is replacing (if so, need date of prior placement), prep and seat dates
D6791	Retainer crown - full cast predominantly base metal	Predetermination Recommended	Dental Necessity	X-rays, list of all missing teeth in both arches, list of all existing bridgework and/or dentures in both arches, indicate if there was any prior bridge or denture that this new bridge is replacing (if so, need date of prior placement), prep and seat dates
D6792	Retainer crown - full cast noble metal	Predetermination Recommended	Dental Necessity	X-rays, list of all missing teeth in both arches, list of all existing bridgework and/or dentures in both arches, indicate if there was any prior bridge or denture that this new bridge is replacing (if so, need date of prior placement), prep and seat dates
D6794	Retainer crown - titanium	Predetermination Recommended	Dental Necessity	X-rays, list of all missing teeth in both arches, list of all existing bridgework and/or dentures in both arches, indicate if there was any prior bridge or denture that this new bridge is replacing (if so, need date of prior placement), prep and seat dates
D6980	Fixed partial denture repair necessitated by restorative material failure	Predetermination Recommended	Dental Necessity	Chart notes or narrative (including when crown was cemented).

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
D6985	Pediatric partial denture, fixed	Predetermination Recommended	Dental Necessity	Narrative
D6999	Unspecified fixed prosthodontic procedure, by report	Predetermination Recommended	Dental Necessity	Chart notes and a narrative
D7251	Coronectomy - intentional partial tooth removal	Predetermination Recommended	Dental Necessity	Narrative
D7260	Oroantral fistula closure	Predetermination Recommended	Dental Necessity	Narrative or surgical operative report
D7261	Primary closure of a sinus perforation	Predetermination Recommended	Dental Necessity	Preoperative periapical x-ray or panoramic x-ray and chart notes, narrative, or surgical operative report
D7270	Tooth re-implantation and/or stabilization of accidentally evulsed or displaced tooth	Predetermination Recommended	Dental Necessity	If dental accident related for review: Dateof accident Description of accident (include if workmen's comp or third party liability involved) X-rays Photos (if available) Chart notes/office records
D7272	Tooth transplantation (includes re-implantation from one site to another and splinting and/or stabilization)	Predetermination Recommended	Dental Necessity	Detailed narrative and/or chart notes
D7283	Placement of device to facilitate eruption of impacted tooth	Predetermination Recommended	Dental Necessity	Narrative
D7284	EXCISIONAL BIOPSY OF MINOR SALIVARY GLANDS	Predetermination Recommended	Medical or Dental Service	Narrative
D7285	Incisional biopsy of oral tissue - hard (bone, tooth)	Predetermination Recommended	Dental Necessity	Diagnosis or narrative of condition (pathology or operative report if applicable)
D7286	Incisional biopsy of oral tissue - soft	Predetermination Recommended	Medical or Dental Service	Diagnosis or narrative of condition (pathology or operative report if applicable)
D7287	Exfoliative cytological sample collection	Predetermination Recommended	Medical or Dental Service	Diagnosis or narrative of condition (pathology or operative report if applicable)
D7288	Brush biopsy - transepithelial sample collection	Predetermination Recommended	Medical or Dental Service	Diagnosis or narrative of condition (pathology or operative report if applicable)

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
D7291	Transseptal fiberotomy/supra crestal fiberotomy, by report	Predetermination Recommended	Dental Necessity	Narrative
D7292	Placement of temporary anchorage device [screw retained plate] requiring flap; includes device removal	Predetermination Recommended	Dental Necessity	Narrative
D7293	Placement of temporary anchorage device requiring flap; includes device removal	Predetermination Recommended	Dental Necessity	Narrative
D7294	Placement of temporary anchorage device without flap; includes device removal	Predetermination Recommended	Dental Necessity	Narrative
D7295	Harvest of bone for use in autogenous grafting procedure	Predetermination Recommended	Dental Necessity	Narrative and/or chart notes
D7340	Vestibuloplasty - ridge extension (secondary epithelialization)	Predetermination Recommended	Dental Necessity	X-rays and operative report
D7350	Vestibuloplasty - ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue)	Predetermination Recommended	Dental Necessity	X-rays and operative report
D7410	Excision of benign lesion up to 1.25 cm	Predetermination Recommended	Medical or Dental Service	Diagnosis or narrative of condition (pathology or operative report if applicable)
D7411	Excision of benign lesion greater than 1.25 cm	Predetermination Recommended	Medical or Dental Service	Diagnosis or narrative of condition (pathology or operative report if applicable)
D7412	Excision of benign lesion, complicated	Predetermination Recommended	Medical or Dental Service	Diagnosis or narrative of condition (pathology or operative report if applicable)
D7413	Excision of malignant lesion up to 1.25 cm	Predetermination Recommended	Medical or Dental Service	Diagnosis or narrative of condition (pathology or operative report if applicable)

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
D7414	Excision of malignant lesion greater than 1.25 cm	Predetermination Recommended	Medical or Dental Service	Diagnosis or narrative of condition (pathology or operative report if applicable)
D7415	Excision of malignant lesion, complicated	Predetermination Recommended	Medical or Dental Service	Diagnosis or narrative of condition (pathology or operative report if applicable)
D7460	Removal of benign nonodontogenic cyst or tumor - lesion diameter up to 1.25 cm	Predetermination Recommended	Medical or Dental Service	Pathology report
D7461	Removal of benign nonodontogenic cyst or tumor - lesion diameter greater than 1.25 cm	Predetermination Recommended	Medical or Dental Service	Pathology report
D7465	Destruction of lesion(s) by physical or chemical method, by report	Predetermination Recommended	Medical or Dental Service	Diagnosis or narrative of condition (pathology or operative report if applicable)
D7471	Removal of lateral exostosis (maxilla or mandible)	Predetermination Recommended	Dental Necessity	Diagnosis or narrative of condition (pathology or operative report if applicable)
D7472	Removal of torus palatinus	Predetermination Recommended	Medical or Dental Service	Panoramic film or photograph only required if there are multiple oral surgery procedures billed on the same claim such as removal of torus, removal of lateral exostosis, surgical reduction of osseous tuberosity, etc.
D7473	Removal of torus mandibularis	Predetermination Recommended	Medical or Dental Service	Panoramic film or photograph only required if there are multiple oral surgery procedures billed on the same claim such as removal of torus, removal of lateral exostosis, surgical reduction of osseous tuberosity, etc.
D7490	Radical resection of maxilla or mandible	Predetermination Recommended	Medical or Dental Service	Diagnosis and pre-operative x-ray
D7530	Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue	Predetermination Recommended	Medical or Dental Service	Narrative
D7540	Removal of reaction producing foreign bodies, musculoskeletal system	Predetermination Recommended	Medical or Dental Service	Narrative

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
D7550	Partial ostectomy/sequestrectomy for removal of non-vital bone	Predetermination Recommended	Dental Necessity	Narrative
D7560	Maxillary sinusotomy for removal of tooth fragment or foreign body	Predetermination Recommended	Medical or Dental Service	Narrative
D7610	Maxilla - open reduction (teeth immobilized, if present)	Predetermination Recommended	Medical or Dental Service	Pre-post op x-rays of teeth involved in the accident, Office records/chart notes, Any third party information, Condition of teeth prior to the accident
D7620	Maxilla - closed reduction (teeth immobilized, if present)	Predetermination Recommended	Medical or Dental Service	Pre-post op x-rays of teeth involved in the accident, Office records/chart notes, Any third party information, Condition of teeth prior to the accident
D7630	Mandible - open reduction (teeth immobilized, if present)	Predetermination Recommended	Medical or Dental Service	Pre-post op x-rays of teeth involved in the accident, Office records/chart notes, Any third party information, Condition of teeth prior to the accident
D7640	Mandible - closed reduction (teeth immobilized, if present)	Predetermination Recommended	Medical or Dental Service	Pre-post op x-rays of teeth involved in the accident, Office records/chart notes, Any third party information, Condition of teeth prior to the accident
D7650	Malar and/or zygomatic arch - open reduction	Predetermination Recommended	Medical or Dental Service	Pre-post op x-rays of teeth involved in the accident, Office records/chart notes, Any third party information, Condition of teeth prior to the accident
D7660	Malar and/or zygomatic arch - closed reduction	Predetermination Recommended	Medical or Dental Service	Pre-post op x-rays of teeth involved in the accident, Office records/chart notes, Any third party information, Condition of teeth prior to the accident
D7670	Alveolus - closed reduction, may include stabilization of teeth	Predetermination Recommended	Medical or Dental Service	Pre-post op x-rays of teeth involved in the accident, Office records/chart notes, Any third party information, Condition of teeth prior to the accident

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D7671	Alveolus - open reduction, may include stabilization of teeth	Predetermination Recommended	Medical or Dental Service	Pre-post op x-rays of teeth involved in the accident, Office records/chart notes, Any third party information, Condition of teeth prior to the accident
D7680	Facial bones - complicated reduction with fixation and multiple surgical approaches	Predetermination Recommended	Medical or Dental Service	Pre-post op x-rays of teeth involved in the accident, Office records/chart notes, Any third party information, Condition of teeth prior to the accident
D7710	Maxilla - open reduction	Predetermination Recommended	Medical Necessity	Narrative
D7720	Maxilla - closed reduction	Predetermination Recommended	Medical Necessity	Narrative
D7730	Mandible - open reduction	Predetermination Recommended	Medical Necessity	Narrative
D7740	Mandible - closed reduction	Predetermination Recommended	Medical Necessity	Narrative
D7750	Malar and/or zygomatic arch - open reduction	Predetermination Recommended	Medical Necessity	Narrative
D7760	Malar and/or zygomatic arch - closed reduction	Predetermination Recommended	Medical Necessity	Narrative
D7770	Alveolus - open reduction stabilization of teeth	Predetermination Recommended	Medical Necessity	Narrative
D7771	Alveolus, closed reduction stabilization of teeth	Predetermination Recommended	Medical Necessity	Narrative
D7780	Facial bones - complicated reduction with fixation and multiple approaches	Predetermination Recommended	Medical Necessity	Narrative
D7810	Open reduction of dislocation	Predetermination Recommended	Medical Necessity	CPT code, description of service, and diagnosis
D7820	Closed reduction of dislocation	Predetermination Recommended	Medical Necessity	CPT code, description of service, and diagnosis
D7830	Manipulation under anesthesia	Prior Authorization Required	Medical Necessity	Complete the Dental Prior Authorization form: https://www.premera.com/documents/030000.pdf and FAX completed form to 425-918-5956 for review. CPT code, description of service, and diagnosis

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
D7840	Condylectomy	Prior Authorization Required	Medical Necessity	Complete the Dental Prior Authorization form: https://www.premera.com/documents/030000.pdf and FAX completed form to 425-918-5956 for review. CPT code, description of service, and diagnosis
D7850	Surgical discectomy, with/without implant	Predetermination Recommended	Medical Necessity	CPT code, description of service, and diagnosis
D7852	Disc repair	Predetermination Recommended	Medical Necessity	CPT code, description of service, and diagnosis
D7854	Synovectomy	Predetermination Recommended	Medical Necessity	CPT code, description of service, and diagnosis
D7856	Myotomy	Predetermination Recommended	Medical Necessity	CPT code, description of service, and diagnosis
D7858	Joint reconstruction	Predetermination Recommended	Medical Necessity	CPT code, description of service, and diagnosis
D7860	Arthrotomy	Predetermination Recommended	Medical Necessity	CPT code, description of service, and diagnosis
D7865	Arthroplasty	Predetermination Recommended	Medical Necessity	CPT code, description of service, and diagnosis
D7870	Arthrocentesis	Predetermination Recommended	Medical Necessity	CPT code, description of service, and diagnosis
D7871	Non-arthroscopic lysis and lavage	Predetermination Recommended	Medical Necessity	CPT code, description of service, and diagnosis
D7872	Arthroscopy - diagnosis, with or without biopsy	Predetermination Recommended	Medical Necessity	CPT code, description of service, and diagnosis
D7873	Arthroscopy: lavage and lysis of adhesions	Predetermination Recommended	Medical Necessity	CPT code, description of service, and diagnosis
D7874	Arthroscopy: disc repositioning and stabilization	Predetermination Recommended	Medical Necessity	CPT code, description of service, and diagnosis
D7875	Arthroscopy: synovectomy	Predetermination Recommended	Medical Necessity	CPT code, description of service, and diagnosis
D7876	Arthroscopy: discectomy	Predetermination Recommended	Medical Necessity	CPT code, description of service, and diagnosis

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
D7877	arthroscopy: debridement	Predetermination Recommended	Medical Necessity	CPT code, description of service, and diagnosis
D7880	Occlusal Orthotic Device, by report	Predetermination Recommended	Medical Necessity	Name and type of appliance including materials used in lab processing (Needed to determine if hard or soft appliance and full arch/coverage or partial-arch appliance). Diagnosis, including a narrative of the patients signs or symptoms Treatment plan
D7881	Occlusal orthotic device adjustment	Predetermination Recommended	Medical Necessity	Name and type of appliance including materials used in lab processing (Needed to determine if hard or soft appliance and full arch/coverage or partial-arch appliance). Diagnosis, including a narrative of the patients signs or symptoms Treatment plan
D7899	Unspecified TMD therapy, by report	Predetermination Recommended	Medical Necessity	CPT code, description of service, and diagnosis
D7910	Suture of recent small wounds up to 5 cm	Predetermination Recommended	Medical or Dental Service	Narrative If related to a dental accident: Pre-post op x-rays of teeth involved in the accident Office records/chart notes Any third party information Condition of teeth prior to the accident
D7911	Complicated suture - up to 5 cm	Predetermination Recommended	Medical or Dental Service	Narrative
D7912	Complicated suture - greater than 5 cm	Predetermination Recommended	Medical or Dental Service	Narrative
D7920	Skin graft (identify defect covered, location and type of graft)	Predetermination Recommended	Medical or Dental Service	Diagnosis or narrative of condition and/or pathology or operative report if applicable
D7921	Collection and application of autologous blood concentrate product	Predetermination Recommended	Medical or Dental Service	Diagnosis or narrative of condition and/or pathology or operative report if applicable
D7922	Placement of intra-socket biological dressing to aid in hemostasis or clot stabilization, per site	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.

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D7940	Osteoplasty - for orthognathic deformities	Predetermination Recommended	Medical or Dental Service	Diagnosis or narrative of condition and/or pathology or operative report if applicable
D7941	Osteotomy - mandibular rami	Predetermination Recommended	Medical or Dental Service	Diagnosis or narrative of condition and/or pathology or operative report if applicable
D7943	Osteotomy - mandibular rami with bone graft; includes obtaining the graft	Predetermination Recommended	Medical or Dental Service	Diagnosis or narrative of condition and/or pathology or operative report if applicable
D7944	Osteotomy - segmented or subapical	Predetermination Recommended	Medical or Dental Service	Diagnosis or narrative of condition and/or pathology or operative report if applicable
D7945	Osteotomy - body of mandible	Predetermination Recommended	Medical or Dental Service	Diagnosis or narrative of condition and/or pathology or operative report if applicable
D7946	LeFort I (maxilla - total)	Predetermination Recommended	Medical Necessity	Diagnosis or narrative of condition and/or pathology or operative report if applicable
D7947	LeFort I (maxilla - segmented)	Predetermination Recommended	Medical Necessity	Diagnosis or narrative of condition and/or pathology or operative report if applicable
D7948	LeFort II or LeFort III (osteoplasty of facial bones for midface hypoplasia or retrusion) - without bone graft	Predetermination Recommended	Medical Necessity	Diagnosis or narrative of condition and/or pathology or operative report if applicable
D7949	LeFort II or LeFort III - with bone graft	Predetermination Recommended	Medical Necessity	Diagnosis or narrative of condition and/or pathology or operative report if applicable
D7950	Osseous, osteoperiosteal, or cartilage graft of the mandible or maxilla - autogenous or nonautogenous, by report	Predetermination Recommended	Dental Necessity	X-rays, narrative and/or chart notes
D7951	Sinus augmentation with bone or bone substitutes via a lateral open approach	Predetermination Recommended	Medical or Dental Service	X-ray(s), narrative and rationale for surgery. A complete treatment plan is recommended

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
D7952	Sinus augmentation via a vertical approach	Predetermination Recommended	Medical or Dental Service	X-ray(s), narrative and rationale for surgery. A complete treatment plan is recommended
D7953	Bone replacement graft for ridge preservation - per site	Predetermination Recommended	Dental Necessity	Periapical x-ray and detailed narrative including diagnosis if applicable.
D7955	Repair of maxillofacial soft and/or hard tissue defect	Predetermination Recommended	Medical Necessity	X-rays and chart notes and/or narrative detailing defect
D7960	Frenulectomy - also known as frenectomy or frenotomy - separate procedure not incidental to another procedure	Predetermination Recommended	Medical or Dental Service	Diagnosis, chart notes, and/or narrative
D7961	Buccal / Labial frenectomy (frenulectomy)	Predetermination Recommended	Medical or Dental Service	Diagnosis, chart notes, and/or narrative
D7970	Excision of hyperplastic tissue - per arch	Predetermination Recommended	Dental Necessity	Detailed narrative and/or chart notes
D7971	Excision of pericoronal gingiva	Predetermination Recommended	Dental Necessity	Perio charting, detailed narrative and/or chart notes
D7972	Surgical reduction of fibrous tuberosity	Predetermination Recommended	Medical or Dental Service	Narrative
D7981	Excision of salivary gland, by report	Predetermination Recommended	Medical or Dental Service	Narrative
D7982	Sialodochoplasty	Predetermination Recommended	Medical or Dental Service	Narrative
D7983	Closure of salivary fistula	Predetermination Recommended	Medical or Dental Service	Narrative
D7990	Emergency tracheotomy	Predetermination Recommended	Medical Necessity	Narrative
D7991	Coronoidectomy	Predetermination Recommended	Medical or Dental Service	Narrative
D7993	Surgical placement of craniofacial implant – extra oral surgical placement of a craniofacial implant to aid in retention of an auricular, nasal, or orbital prosthesis	Predetermination Recommended	Medical or Dental Service	Submit chart notes and narrative to review for medical/dental necessity
D7994	Surgical placement: zygomatic implant an implant placed in the zygomatic bone and exiting through the maxillary mucosal tissue providing support and attachment of a maxillary	Predetermination Recommended	Medical or Dental Service	Submit chart notes and narrative to review for medical/dental necessity

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D7995	Synthetic graft - mandible or facial bones, by report	Predetermination Recommended	Dental Necessity	X-rays and chart notes
D7996	Implant-mandible for augmentation purposes (excluding alveolar ridge), by report	Predetermination Recommended	Dental Necessity	X-rays and chart notes
D7997	Appliance removal (not by dentist who placed appliance), includes removal of archbar	Predetermination Recommended	Medical or Dental Service	Detailed narrative and/or chart notes
D7998	Intraoral placement of a fixation device not in conjunction with a fracture	Predetermination Recommended	Dental Necessity	Narrative and chart notes. Pre-operative x-rays may be required
D7999	Unspecified oral surgery procedure, by report	Predetermination Recommended	Dental Necessity	Chart notes and a narrative
D8010	Limited orthodontic treatment of the primary dentition	Prior Authorization Required	Medical Necessity	Complete the Dental Prior Authorization form for MEDICAL Orthodontia https://www.premera.com/documents/030000.pdf and FAX completed form to 425-918-5956 for review. Medically necessary orthodontia may require diagnosis, history & physical documenting the congenital anomaly, treatment plan including duration of treatment, initial banding, monthly adjustments, and retention care, and any diagnostic studies such as x-rays, images, or study models.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
D8020	Limited orthodontic treatment of the transitional dentition	Prior Authorization Required	Medical Necessity	Complete the Dental Prior Authorization form for MEDICAL Orthodontia https://www.premera.com/documents/030000.pdf and FAX completed form to 425-918-5956 for review. Medically necessary orthodontia may require diagnosis, history & physical documenting the congenital anomaly, treatment plan including duration of treatment, initial banding, monthly adjustments, and retention care, and any diagnostic studies such as x-rays, images, or study models.
D8030	Limited orthodontic treatment of the adolescent dentition	Prior Authorization Required	Medical Necessity	Complete the Dental Prior Authorization form for MEDICAL Orthodontia https://www.premera.com/documents/030000.pdf and FAX completed form to 425-918-5956 for review. Medically necessary orthodontia may require diagnosis, history & physical documenting the congenital anomaly, treatment plan including duration of treatment, initial banding, monthly adjustments, and retention care, and any diagnostic studies such as x-rays, images, or study models.

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D8040	Limited orthodontic treatment of the adult dentition	Prior Authorization Required	Medical Necessity	Complete the Dental Prior Authorization form for MEDICAL Orthodontia https://www.premera.com/documents/030000.pdf and FAX completed form to 425-918-5956 for review. Medically necessary orthodontia may require diagnosis, history & physical documenting the congenital anomaly, treatment plan including duration of treatment, initial banding, monthly adjustments, and retention care, and any diagnostic studies such as x-rays, images, or study models.
D8050	Interceptive orthodontic treatment of the primary dentition	Prior Authorization Required	Medical Necessity	Complete the Dental Prior Authorization form: https://www.premera.com/documents/030000.pdf and FAX completed form to 425-918-5956 for review. Routine Orthodontia treatment plan that includes a breakdown of charges that would include initial banding, monthly adjustments, and retention care. Medically necessary orthodontia may require diagnosis, history & physical documenting the congenital anomaly, treatment plan including duration of treatment, and any diagnostic studies such as x-rays, images, or study models

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
D8060	Interceptive orthodontic treatment of the transitional dentition	Prior Authorization Required	Medical Necessity	Complete the Dental Prior Authorization form: https://www.premera.com/documents/030000.pdf and FAX completed form to 425-918-5956 for review. Routine Orthodontia treatment plan that includes a breakdown of charges that would include initial banding, monthly adjustments, and retention care. Medically necessary orthodontia may require diagnosis, history & physical documenting the congenital anomaly, treatment plan including duration of treatment, and any diagnostic studies such as x-rays, images, or study models
D8070	Comprehensive orthodontic treatment of the transitional dentition	Prior Authorization Required	Medical Necessity	Complete the Dental Prior Authorization form for MEDICAL Orthodontia https://www.premera.com/documents/030000.pdf and FAX completed form to 425-918-5956 for review. Medically necessary orthodontia may require diagnosis, history & physical documenting the congenital anomaly, treatment plan including duration of treatment, initial banding, monthly adjustments, and retention care, and any diagnostic studies such as x-rays, images, or study models.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
D8080	Comprehensive orthodontic treatment of the adolescent dentition	Prior Authorization Required	Medical Necessity	Complete the Dental Prior Authorization form for MEDICAL Orthodontia https://www.premera.com/documents/030000.pdf and FAX completed form to 425-918-5956 for review. Medically necessary orthodontia may require diagnosis, history & physical documenting of the congenital anomaly, treatment plan including duration of treatment, initial banding, monthly adjustments, and retention care, and any diagnostic studies such as x-rays, images, or study models.
D8090	Comprehensive orthodontic treatment of the adult dentition	Prior Authorization Required	Medical Necessity	Complete the Dental Prior Authorization form for MEDICAL Orthodontia https://www.premera.com/documents/030000.pdf and FAX completed form to 425-918-5956 for review. Medically necessary orthodontia may require diagnosis, history & physical documenting the congenital anomaly, treatment plan including duration of treatment, initial banding, monthly adjustments, and retention care, and any diagnostic studies such as x-rays, images, or study models.
D8210	Removable appliance therapy	Prior Authorization Required	Medical Necessity	Complete the Dental Prior Authorization form: https://www.premera.com/documents/030000.pdf and FAX completed form to 425-918-5956 for review. Include the Narrative.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
D8220	Fixed appliance therapy	Prior Authorization Required	Medical Necessity	Complete the Dental Prior Authorization form: https://www.premera.com/documents/030000.pdf and FAX completed form to 425-918-5956 for review. Include the Narrative.
D8999	Unspecified orthodontic procedure, by report	Prior Authorization Required	Medical Necessity	Complete the Dental Prior Authorization form: https://www.premera.com/documents/030000.pdf and FAX completed form to 425-918-5956 for review. Include chart notes and a narrative.
D9120	Fixed partial denture sectioning	Predetermination Recommended	Dental Necessity	Narrative and/or chart notes describing the necessity for this service
D9210	Local anesthesia not in conjunction with operative or surgical procedures	Predetermination Recommended	Dental Necessity	Chart notes and/or narrative describing procedure performed.
D9211	Regional block anesthesia	Predetermination Recommended	Dental Necessity	Narrative
D9212	Trigeminal division block anesthesia	Predetermination Recommended	Dental Necessity	Narrative
D9215	Local anesthesia in conjunction with operative or surgical procedures	Predetermination Recommended	Dental Necessity	Narrative
D9222	Deep sedation/general anesthesia-First 15 minutes	Predetermination Recommended	Medical Necessity	Narrative, Chart Notes, Diagnosis supporting Medical Necessity
D9223	Deep sedation/general anesthesia-Each subsequent 15 minute increment	Predetermination Recommended	Medical Necessity	Narrative, Chart Notes, Diagnosis supporting Medical Necessity
D9248	Non-intravenous conscious sedation	Predetermination Recommended	Dental Necessity	Narrative
D9930	Treatment of complications (post-surgical) - unusual circumstances, by report	Predetermination Recommended	Dental Necessity	Chart notes and a narrative

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D9947	CUSTOM SLEEP APNEA APPLIANCE FABRICATION AND PLACEMENT	Prior Authorization Required	Advanced Imaging	Submit an online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results or previous diagnostic procedure report. For standalone dental plans that do not have medical with Premera, DO NOT submit to Carelon. Complete the Dental Prior Authorization form: https://www.premera.com/documents/030000.pdf and FAX completed form to 425-918-5956 for review. Include chart notes, narrative, and a sleep study.
D9951	Occlusal adjustment - limited	Predetermination Recommended	Dental Necessity	Tooth number(s)
D9952	Occlusal adjustment - complete	Predetermination Recommended	Dental Necessity	Narrative stating treatment rationale, full mouth radiograpic series if bony defects present, periodontal charting showing the mobilities and occlusal findings (if applicable)
D9954	Fabrication and delivery of oral appliance therapy (OAT) morning repositioning device	Generally Not Covered	Dental Necessity	Submit diagnosis, prognosis and chart notes including history of non-invasive or non-surgical attempts to treat the TMJ.
D9997	Dental case management patients with special health care needs	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
D9999	Unspecified adjunctive procedure, by report	Predetermination Recommended	Dental Necessity	Chart notes and/or narrative describing procedure performed.
E0152	Walker, battery powered, wheeled, folding, adjustable or fixed height	Non-covered Service	Not Covered	This service is not covered by the member's contract.
E0170	Commode chair with integrated seat lift mechanism, electric, any type	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
E0171	Commode chair with integrated seat lift mechanism, nonelectric, any type	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.

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E0172	Seat lift mechanism placed over or on top of toilet, any type	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
E0175	Footrest, for use with commode chair, each	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
E0190	Positioning cushion/pillow/wedge, any shape or size, includes all components and accessories	Non-covered Service	Benefit Exception	Submit records only when a contract exception exists. May be considered medically necessary for infants with GERD, please refer to medical policy 1.01.530.
E0193	Powered air flotation bed (low air loss therapy)	Prior Authorization Required	Medical Necessity	Letter of medical necessity containing the following information: Anticipated length of time patient will require the equipment, description of medical condition requiring use of this equipment including mobility status.
E0194	Air fluidized bed	Prior Authorization Required	Medical Necessity	Letter of medical necessity containing the following information: Anticipated length of time patient will require the equipment, description of medical condition requiring use of this equipment including mobility status.
E0218	Fluid circulating cold pad with pump, any type	Pre-Service Review Required	Medical Necessity	Letter of Medical Necessity including length of time equipment needed,functional status if applicable and description of medical condition. Include invoice of cost for item.
E0236	Pump for water circulating pad	Pre-Service Review Required	Medical Necessity	Letter of Medical Necessity including length of time equipment needed,functional status if applicable and description of medical condition. Include invoice of cost for item.
E0241	Bathtub wall rail, each	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.

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E0242	Bathtub rail, floor base	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
E0243	Toilet rail, each	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
E0246	Transfer tub rail attachment	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
E0250	Hospital bed, fixed height, with any type side rails, with mattress	Prior Authorization Required	Medical Necessity	Letter of medical necessity containing the following information: Anticipated length of time patient will require the equipment, description of medical condition requiring use of this equipment including mobility status.
E0251	Hospital bed, fixed height, with any type side rails, without mattress	Prior Authorization Required	Medical Necessity	Letter of medical necessity containing the following information: Anticipated length of time patient will require the equipment, description of medical condition requiring use of this equipment including mobility status.
E0255	Hospital bed, variable height, hi-lo, with any type side rails, with mattress	Prior Authorization Required	Medical Necessity	Letter of medical necessity containing the following information: Anticipated length of time patient will require the equipment, description of medical condition requiring use of this equipment including mobility status.
E0256	Hospital bed, variable height, hi-lo, with any type side rails, without mattress	Prior Authorization Required	Medical Necessity	Letter of medical necessity containing the following information: Anticipated length of time patient will require the equipment, description of medical condition requiring use of this equipment including mobility status.

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E0260	Hospital bed, semi-electric (head and foot adjustment), with any type side rails, with mattress	Prior Authorization Required	Medical Necessity	Letter of medical necessity including mobility status and anticipated length of time patient will require the equipment. No review needed for first 3 months of rental. Rental period is 10 months, then transitions to purchase.
E0261	Hospital bed, semi-electric (head and foot adjustment), with any type side rails, without mattress	Prior Authorization Required	Medical Necessity	Letter of medical necessity including mobility status and anticipated length of time patient will require the equipment.
E0265	Hospital bed, total electric (head, foot, and height adjustments), with any type side rails, with mattress	Prior Authorization Required	Medical Necessity	Letter of medical necessity including mobility status and anticipated length of time patient will require the equipment. No review needed if Rental.
E0266	Hospital bed, total electric (head, foot, and height adjustments), with any type side rails, without mattress	Prior Authorization Required	Medical Necessity	Letter of medical necessity including mobility status and anticipated length of time patient will require the equipment. No review needed if Rental.
E0270	Hospital bed, institutional type includes: oscillating, circulating and Stryker frame, with mattress	Prior Authorization Required	Medical Necessity	Letter of medical necessity containing the following information: Anticipated length of time patient will require the equipment, description of medical condition requiring use of this equipment including mobility status.
E0273	Bed board	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
E0274	Over-bed table	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
E0277	Powered pressure-reducing air mattress	Prior Authorization Required	Medical Necessity	Letter of medical necessity containing the following information: Anticipated length of time patient will require the equipment, description of medical condition requiring use of this equipment including mobility status.

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E0290	Hospital bed, fixed height, without side rails, with mattress	Prior Authorization Required	Medical Necessity	Letter of medical necessity containing the following information: Anticipated length of time patient will require the equipment, Description of medical condition requiring use of special bed; including mobility status
E0291	Hospital bed, fixed height, without side rails, without mattress	Prior Authorization Required	Medical Necessity	Letter of medical necessity containing the following information: Anticipated length of time patient will require the equipment, Description of medical condition requiring use of special bed; including mobility status
E0292	Hospital bed, variable height, hi-lo, without side rails, with mattress	Prior Authorization Required	Medical Necessity	Letter of medical necessity containing the following information: Anticipated length of time patient will require the equipment, Description of medical condition requiring use of special bed; including mobility status
E0293	Hospital bed, variable height, hi-lo, without side rails, without mattress	Prior Authorization Required	Medical Necessity	Letter of medical necessity containing the following information: Anticipated length of time patient will require the equipment, Description of medical condition requiring use of special bed; including mobility status
E0294	Hospital bed, semi-electric (head and foot adjustment), without side rails, with mattress	Prior Authorization Required	Medical Necessity	Letter of medical necessity including mobility status and anticipated length of time patient will require the equipment.
E0295	Hospital bed, semi-electric (head and foot adjustment), without side rails, without mattress	Prior Authorization Required	Medical Necessity	Letter of medical necessity including mobility status and anticipated length of time patient will require the equipment.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
E0296	Hospital bed, total electric (head, foot, and height adjustments), without side rails, with mattress	Prior Authorization Required	Medical Necessity	Letter of medical necessity including mobility status and anticipated length of time patient will require the equipment. No review needed if Rental.
E0297	Hospital bed, total electric (head, foot, and height adjustments), without side rails, without mattress	Prior Authorization Required	Medical Necessity	Letter of medical necessity including mobility status and anticipated length of time patient will require the equipment. No review needed if Rental.
E0300	Pediatric crib, hospital grade, fully enclosed	Prior Authorization Required	Medical Necessity	Letter of medical necessity including mobility status and anticipated length of time patient will require the equipment. No review needed if Rental.
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 Required	Medical Necessity	Letter of medical necessity containing the following information: Anticipated length of time patient will require the equipment, Description of medical condition requiring use of special bed; including mobility status
E0302	Hospital bed, extra heavy duty, extra wide, with weight capacity greater than 600 pounds, with any type side rails, without mattress	Prior Authorization Required	Medical Necessity	Letter of medical necessity containing the following information: Anticipated length of time patient will require the equipment, Description of medical condition requiring use of special bed; including mobility status
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 Required	Medical Necessity	Letter of medical necessity containing the following information: Anticipated length of time patient will require the equipment, Description of medical condition requiring use of special bed; including mobility status

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
E0304	Hospital bed, extra heavy-duty, extra wide, with weight capacity greater than 600 pounds, with any type side rails, with mattress	Prior Authorization Required	Medical Necessity	Letter of medical necessity containing the following information: Anticipated length of time patient will require the equipment, Description of medical condition requiring use of special bed; including mobility status
E0315	Bed accessory: board, table, or support device, any type	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
E0316	Safety enclosure frame/canopy for use with hospital bed, any type	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
E0328	Hospital bed, pediatric, manual, 360 degree side enclosures, top of headboard, footboard and side rails up to 24 inches above the spring, includes mattress	Prior Authorization Required	Medical Necessity	Letter of medical necessity including mobility status and anticipated length of time patient will require the equipment.
E0329	Hospital bed, pediatric, electric or semi-electric, 360 degree side enclosures, top of headboard, footboard and side rails up to 24 inches above the spring, includes mattress	Prior Authorization Required	Medical Necessity	Letter of medical necessity including mobility status and anticipated length of time patient will require the equipment.
E0371	Nonpowered advanced pressure reducing overlay for mattress, standard mattress length and width	Prior Authorization Required	Medical Necessity	Letter of medical necessity containing the following information: Anticipated length of time patient will require the equipment, description of medical condition requiring use of this equipment including mobility status.
E0372	Powered air overlay for mattress, standard mattress length and width	Prior Authorization Required	Medical Necessity	Letter of medical necessity containing the following information: Anticipated length of time patient will require the equipment, description of medical condition requiring use of this equipment including mobility status.
E0373	Nonpowered advanced pressure reducing mattress	Prior Authorization Required	Medical Necessity	History & physical, including size, depth, location of decubiti.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
E0446	Topical oxygen delivery system, not otherwise specified, includes all supplies and accessories	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
E0469	Lung expansion airway clearance, continuous high frequency oscillation, and nebulization device	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
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	Compliance	Sleep Devices and Equipment	Compliance information is required for sleep apnea equipment supplies. Submit online review with Carelon at www.providerportal.com during rental period. Post rental period and diagnosis other than sleep apnea, no review required.
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)	Compliance	Sleep Devices and Equipment	Compliance information is required for sleep apnea equipment supplies. Submit online review with Carelon at www.providerportal.com during rental period. Post rental period and diagnosis other than sleep apnea, no review required.
E0481	Intrapulmonary percussive ventilation system and related accessories	Prior Authorization Required	Medical Necessity	Submit letter of medical necessity including length of time equipment needed, functional status if applicable and description of medical condition.
E0483	High frequency chest wall oscillation system, with full anterior and/or posterior thoracic region receiving simultaneous external oscillation, includes all accessories and supplies, each	Prior Authorization Required	Medical Necessity	Submit letter of medical necessity including length of time equipment needed, functional status if applicable and description of medical condition.
E0484	Oscillatory positive expiratory pressure device, nonelectric, any type, each	Prior Authorization Required	Medical Necessity	Submit letter of medical necessity including length of time equipment needed, functional status if applicable and description of medical condition.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
E0485	Oral device/appliance used to reduce upper airway collapsibility, adjustable or nonadjustable, prefabricated, includes fitting and adjustment	Prior Authorization Required	Sleep Devices and Equipment	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
E0486	Oral device/appliance used to reduce upper airway collapsibility, adjustable or nonadjustable, custom fabricated, includes fitting and adjustment	Prior Authorization Required	Sleep Devices and Equipment	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
E0490	Power source and control electronics unit for oral device/appliance for neuromuscular electrical stimulation of the tongue muscle, controlled by hardware remote	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
E0491	Oral device/appliance for neuromuscular electrical stimulation of tongue muscle, used in conjunction with power source & control electrical unit, controlled by hardware remote 90 day supply	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
E0492	Power source and control electronics unit for oral device/appliance for neuromuscular electrical stimulation of the tongue muscle, controlled by phone application	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
E0493	Oral device/appliance for neuromuscular electrical stimulation of tongue muscle, used in conjunction with the power source & control electronics unit, controlled by phone, 90 day supply	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
E0530	Electronic positional obstructive sleep apnea treatment, with sensor, includes all components and accessories, any type	Possible Denial; Medical Records Optional	Investigative	Documentation optional.

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E0561	Humidifier, nonheated, used with positive airway pressure device	Compliance	Sleep Devices and Equipment	Compliance information is required for sleep apnea equipment supplies. Submit online review with Carelon at www.providerportal.com during rental period. Post rental period and diagnosis other than sleep apnea, no review required.
E0562	Humidifier, heated, used with positive airway pressure device	Compliance	Sleep Devices and Equipment	Compliance information is required for sleep apnea equipment supplies. Submit online review with Carelon at www.providerportal.com during rental period. Post rental period and diagnosis other than sleep apnea, no review required.
E0574	Ultrasonic/electronic aerosol generator with small volume nebulizer	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
E0575	Nebulizer, ultrasonic, large volume	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
E0601	Continuous positive airway pressure (CPAP) device	Compliance	Sleep Devices and Equipment	Compliance information is required for sleep apnea equipment supplies. Submit online review with Carelon at www.providerportal.com during rental period. Post rental period and diagnosis other than sleep apnea, no review required.
E0602	Breast pump, manual, any type	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
E0605	Vaporizer, room type	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
E0617	External defibrillator with integrated electrocardiogram analysis	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
E0621	Sling or seat, patient lift, canvas or nylon	Prior Authorization Required	Medical Necessity	Letter of medical necessity containing the following information: Anticipated length of time patient will require the equipment, description of medical condition requiring use of this equipment including mobility status.
E0625	Patient lift, bathroom or toilet, not otherwise classified	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
E0627	Seat lift mechanism incorporated into a combination lift-chair mechanism	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
E0629	Separate seat lift mechanism for use with patient-owned furniture, nonelectric	Prior Authorization Required	Medical Necessity	Letter of medical necessity containing the following information: Anticipated length of time patient will require the equipment, description of medical condition requiring use of this equipment including mobility status.
E0630	Patient lift; hydraulic or mechanical, includes any seat, sling, strap(s), or pad(s)	Prior Authorization Required	Medical Necessity	Letter of medical necessity containing the following information: Anticipated length of time patient will require the equipment, description of medical condition requiring use of this equipment including mobility status.
E0635	Patient lift, electric, with seat or sling	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
E0636	Multipositional patient support system, with integrated lift, patient accessible contr	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
E0637	Combination sit and stand system, any size, with seat lift feature, with or without wheels	Prior Authorization Required	Medical Necessity	Letter of medical necessity containing the following information: Anticipated length of time patient will require the equipment, description of medical condition requiring use of this equipment including mobility status.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
E0638	Standing frame system, one position (e.g., upright, supine or prone stander), any size including pediatric, with or without wheels	Prior Authorization Required	Medical Necessity	Letter of medical necessity containing the following information: Anticipated length of time patient will require the equipment, description of medical condition requiring use of this equipment including mobility status.
E0639	Patient lift, moveable from room to room with disassembly and reassembly, includes all components/accessories	Prior Authorization Required	Medical Necessity	Letter of medical necessity containing the following information: Anticipated length of time patient will require the equipment, description of medical condition requiring use of this equipment including mobility status.
E0640	Patient lift, fixed system, includes all components/accessories	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
E0641	Standing frame system, multi-position (e.g., three-way stander,), any size including pediatric, with or without wheels	Prior Authorization Required	Medical Necessity	Letter of medical necessity, including condition being treated.
E0642	Standing frame system, mobile (dynamic stander), any size including pediatric	Prior Authorization Required	Medical Necessity	Letter of medical necessity, including condition being treated.
E0650	Pneumatic compressor, nonsegmental home model	Pre-Service Review Required	Medical Necessity	Letter of medical necessity containing the following information: Anticipated length of time patient will require the equipment, description of medical condition requiring use of this equipment including mobility status.
E0651	Pneumatic compressor, segmental home model without calibrated gradient pressure	Pre-Service Review Required	Medical Necessity	Letter of medical necessity containing the following information: Anticipated length of time patient will require the equipment, description of medical condition requiring use of this equipment including mobility status.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
E0652	Pneumatic compressor, segmental home model with calibrated gradient pressure	Prior Authorization Required	Medical Necessity	Letter of medical necessity, including condition being treated.
E0656	Segmental pneumatic appliance for use with pneumatic compressor, trunk	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
E0657	Segmental pneumatic appliance for use with pneumatic compressor, chest	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
E0670	Segmental pneumatic appliance for use with pneumatic compressor, integrated, 2 full legs and trunk	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
E0673	Segmental gradient pressure pneumatic appliance, half leg	Prior Authorization Required	Medical Necessity	Letter of medical necessity, including condition being treated.
E0675	Pneumatic compression device, high pressure, rapid inflation/deflation cycle, for arterial insufficiency (unilateral or bilateral system)	Prior Authorization Required	Medical Necessity	History and Physical including comorbidities, previously tried clinical interventions and operative report if any available
E0676	Intermittent limb compression device (includes all accessories), not otherwise specified	Pre-Service Review Required	Medical Necessity	History and Physical including comorbidities, previously tried clinical interventions and operative report if any available
E0677	Non-pneumatic sequential compression garment, trunk	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
E0678	Non-pneumatic sequential compression garment, full leg	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
E0679	Non-pneumatic sequential compression garment, half leg	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
E0680	Non-pneumatic compression controller with sequential calibrated gradient pressure	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
E0681	Non-pneumatic compression controller without calibrated gradient pressure	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
E0682	Non-pneumatic sequential compression garment, full arm	Possible Denial; Medical Records Optional	Investigative	Documentation optional.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
E0683	Non-pneumatic, non-sequential, peristaltic wave compression pump	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
E0700	Safety equipment (e.g., belt, harness, or vest)	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
E0710	Restraints, any type (body, chest, wrist, or ankle)	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
E0715	Intravaginal device intended to strengthen pelvic floor muscles during kegel exercises	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
E0716	Supplies and accessories for intravaginal device intended to strengthen pelvic floor muscles during kegel exercises	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
E0721	Transcutaneous electrical nerve stimulator for nerves in the auricular region	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
E0732	Cranial electrotherapy stimulation (CES) system, any type	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
E0733	Transcutaneous electrical nerve stimulator for electrical stimulation of the trigeminal nerve	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
E0734	External upper limb tremor stimulator of the peripheral nerves of the wrist	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
E0735	Non-invasive vagus nerve stimulator	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
E0736	Transcutaneous tibial nerve stimulator	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
E0737	Transcutaneous tibial nerve stimulator, controlled by phone application	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
E0738	Upper extremity rehabilitation system providing active assistance to facilitate muscle re-education, include microprocessor, all components and accessories	Possible Denial; Medical Records Optional	Investigative	Documentation optional.

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E0739	Rehabilitation system with interactive interface providing active assistance in rehabilitation therapy, includes all components and accessories, motors, microprocessors, sensors	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
E0743	External lower extremity nerve stimulator for restless legs syndrome, each	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
E0745	Neuromuscular stimulator, electronic shock unit	Prior Authorization Required	Medical Necessity	History and Physical including comorbidities, previously tried clinical interventions and operative report if any available
E0747	Osteogenesis stimulator, electrical, noninvasive, other than spinal applications	Prior Authorization Required	Medical Necessity	History and Physical indicating location of fracture and any member comorbidities. If request is for non union fracture, include date of fracture, serial radiographs detailing any history of healing, fracture gap, documentation of adequacy of immobilization
E0748	Osteogenic stimulator, electrical, non-invasive, spinal applications	Prior Authorization Required	Medical Necessity	History and Physical indicating location of fracture and any member comorbidities. If request is for non union fracture, include date of fracture, serial radiographs detailing any history of healing, fracture gap, documentation of adequacy of immobilization
E0749	Osteogenesis stimulator, electrical, surgically implanted	Prior Authorization Required	Medical Necessity	History and Physical indicating location of fracture and any member comorbidities. If request is for non union fracture, include date of fracture, serial radiographs detailing any history of healing, fracture gap, documentation of adequacy of immobilization

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
E0760	Osteogenesis stimulator, low intensity ultrasound, non-invasive	Prior Authorization Required	Medical Necessity	History and Physical indicating location of fracture and any member comorbidities. If request is for non union fracture, include date of fracture, serial radiographs detailing any history of healing, fracture gap, documentation of adequacy of immobilization
E0761	Nonthermal pulsed high frequency radiowaves, high peak power electromagnetic energy treatment device	Prior Authorization Required	Investigative	Submit history and physical, documentation of medical necessity and procedure report.
E0762	Transcutaneous electrical joint stimulation device system, includes all accessories	Prior Authorization Required	Investigative	Submit letter of medical necessity including length of time equipment needed, functional status if applicable and description of medical condition.
E0764	Functional neuromuscular stimulator, transcutaneous stimulation of muscles of ambulation with computer control, used for walking by spinal cord injured, entire system, after completion of training program	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
E0765	FDA approved nerve stimulator, with replaceable batteries, for treatment of nausea and vomiting	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
E0766	Electrical stimulation device used for cancer treatment, includes all accessories, any type	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
E0767	Intrabuccal, systemic delivery of amplitude-modulated, radiofrequency electromagnetic field device, for cancer treatment, includes all accessories	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
E0769	Electrical stimulation or electromagnetic wound treatment device, not otherwise classified	Possible Denial; Medical Records Optional	Investigative	Documentation optional.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
E0770	Functional electrical stimulator, transcutaneous stimulation of nerve, and/or muscle groups, any type, complete system, not otherwise specified	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
E0936	Continuous passive motion exercise device for use other than knee	Generally Not Covered	Not Medically Necessary	Not medically necessary, documentation optional. See medical policy 1.01.10.
E0941	Gravity assisted traction device, any type	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
E0983	Manual wheelchair accessory, power add-on to convert manual wheelchair to motorized wheelchair, joystick control	Prior Authorization Required	Medical Necessity	Diagnosis, Abilities and limitations as they relate to the equipment (e.g., degree of independence/ dependence, frequency and nature of the activities the patient performs, duration of medical condition, Past experience if any using similar equipment, Evaluation of upper extremity strength and Documented inability to propel a manual chair
E0984	Power add-on to convert manual wheelchair to motorized wheelchair, tiller cotnrol	Prior Authorization Required	Medical Necessity	Diagnosis, Abilities and limitations as they relate to the equipment (e.g., degree of independence/ dependence, frequency and nature of the activities the patient performs, duration of medical condition, Past experience if any using similar equipment, Evaluation of upper extremity strength and Documented inability to propel a manual chair.
E0986	Manual wheelchair accessory, push activated power assist, each	Prior Authorization Required	Medical Necessity	Letter of medical Necessity supporting need for the wheelchair accessory
E0988	Manual wheelchair accessory, lever-activated, wheel drive, pair	Prior Authorization Required	Medical Necessity	Documentation of medical necessity, including a physiatrist evaluation.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
E1002	Power seating system, tilt only	Prior Authorization Required	Medical Necessity	Letter of medical Necessity supporting need for the wheelchair accessory.
E1003	Wheelchair accessory, power seating system, recline only, without shear reduction	Prior Authorization Required	Medical Necessity	Letter of medical Necessity supporting need for the wheelchair accessory.
E1004	Wheelchair accessory, power seating system, recline only, with mechanical shear reduction	Prior Authorization Required	Medical Necessity	Letter of medical Necessity supporting need for the wheelchair accessory.
E1005	Wheelchair accessory, power seatng System, recline only, with power shear reduction	Prior Authorization Required	Medical Necessity	Letter of medical Necessity supporting need for the wheelchair accessory.
E1006	Power seating system, combination tilt and recline, without shear reduction	Prior Authorization Required	Medical Necessity	Letter of medical Necessity supporting need for the wheelchair accessory.
E1007	Power seating system, combination tilt and recline, with mechanical sheer reduction	Prior Authorization Required	Medical Necessity	Letter of medical Necessity supporting need for the wheelchair accessory.
E1008	Power seating system, combination tilt and recline, with power shear reduction	Prior Authorization Required	Medical Necessity	Letter of medical Necessity supporting need for the wheelchair accessory.
E1009	Addition to power seating system, mechanically linked leg elevation system, including pushrod and leg rest, each	Prior Authorization Required	Medical Necessity	Letter of medical Necessity supporting need for the wheelchair accessory.
E1010	Addition to power seating system, power leg elevation system, including leg rest, pair	Prior Authorization Required	Medical Necessity	Letter of medical Necessity supporting need for the wheelchair accessory.
E1012	Wheelchair accessory, addition to power seating system, center mount power elevating leg rest/platform, complete system, any type, each	Prior Authorization Required	Medical Necessity	Letter of medical Necessity supporting need for the wheelchair accessory
E1014	Reclining back, addition to pediatric size wheelchair	Prior Authorization Required	Medical Necessity	Letter of medical Necessity supporting need for the wheelchair accessory
E1015	Shock absorber for manual wheelchair, each	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
E1016	Shock absorber for power wheelchair, each	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
E1017	Heavy-duty shock absorber for heavy-duty or extra heavy-duty manual wheelchair, each	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
E1018	Heavy-duty shock absorber for heavy-duty or extra heavy-duty power wheelchair, each	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
E1035	Multi positional patient transfer system, with integrated seat, operated by caregiver	Prior Authorization Required	Medical Necessity	Submit history and physical to include the following: diagnosis; abilities and limitations as they relate to the equipment (e.g., degree of independence/ dependence, frequency and nature of the activities the patient performs, duration of medical condition, past experience if any using similar equipment, evaluation of upper extremity strength.
E1036	Multi-positional patient transfer system, extra-wide, with integrated seat, operated by caregiver, patient weight capacity greater than 300 lbs	Prior Authorization Required	Medical Necessity	Submit history and physical to include the following: diagnosis; abilities and limitations as they relate to the equipment (e.g., degree of independence/ dependence, frequency and nature of the activities the patient performs, duration of medical condition, past experience if any using similar equipment, evaluation of upper extremity strength.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
E1050	Fully-reclining wheelchair, fixed full-length arms, swing-away detachable elevating legrests	Prior Authorization Required	Specialized DME	History and Physical to Include the following: diagnosis; abilities and limitations as they relate to the equipment (e.g., degree of independence/ dependence, frequency and nature of the activities the patient performs, duration of medical condition, Past experience if any using similar equipment, Evaluation of upper extremity strength. Include invoice of cost for item.
E1060	Fully-reclining wheelchair, detachable arms, desk or full-length, swing-away detachable elevating legrests	Prior Authorization Required	Specialized DME	History and Physical to Include the following: diagnosis; abilities and limitations as they relate to the equipment (e.g., degree of independence/ dependence, frequency and nature of the activities the patient performs, duration of medical condition, Past experience if any using similar equipment, Evaluation of upper extremity strength. Include invoice of cost for item.
E1070	Fully-reclining wheelchair, detachable arms (desk or full-length) swing-away detachable footrest	Prior Authorization Required	Specialized DME	History and Physical to Include the following: diagnosis; abilities and limitations as they relate to the equipment (e.g., degree of independence/ dependence, frequency and nature of the activities the patient performs, duration of medical condition, Past experience if any using similar equipment, Evaluation of upper extremity strength. Include invoice of cost for item.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
E1083	Hemi-wheelchair; fixed full-length arms, swing-away, detachable, elevating legrests	Prior Authorization Required	Specialized DME	History and Physical to Include the following: diagnosis; abilities and limitations as they relate to the equipment (e.g., degree of independence/ dependence, frequency and nature of the activities the patient performs, duration of medical condition, Past experience if any using similar equipment, Evaluation of upper extremity strength. Include invoice of cost for item.
E1084	Hemi-wheelchair, detachable arms desk or full-length arms, swing-away detachable elevating legrests	Pre-Service Review Recommended where description of service is available, otherwise Retrospective Medical Review Required	Specialized DME	History and Physical to Include the following: diagnosis; abilities and limitations as they relate to the equipment (e.g., degree of independence/ dependence, frequency and nature of the activities the patient performs, duration of medical condition, Past experience if any using similar equipment, Evaluation of upper extremity strength. Include invoice of cost for item.
E1085	Hemi-wheelchair, fixed full-length arms, swing-away detachable footrests	Prior Authorization Required	Specialized DME	History and Physical to Include the following: diagnosis; abilities and limitations as they relate to the equipment (e.g., degree of independence/ dependence, frequency and nature of the activities the patient performs, duration of medical condition, Past experience if any using similar equipment, Evaluation of upper extremity strength. Include invoice of cost for item.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
E1086	Hemi-wheelchair, detachable arms, desk or full-length, swing-away detachable footrests	Prior Authorization Required	Specialized DME	History and Physical to Include the following: diagnosis; abilities and limitations as they relate to the equipment (e.g., degree of independence/ dependence, frequency and nature of the activities the patient performs, duration of medical condition, Past experience if any using similar equipment, Evaluation of upper extremity strength. Include invoice of cost for item.
E1087	High strength lightweight wheelchair, fixed full-length arms, swing-away detachable elevating legrests	Prior Authorization Required	Specialized DME	History and Physical to Include the following: diagnosis; abilities and limitations as they relate to the equipment (e.g., degree of independence/ dependence, frequency and nature of the activities the patient performs, duration of medical condition, Past experience if any using similar equipment, Evaluation of upper extremity strength. Include invoice of cost for item.
E1088	High strength lightweight wheelchair, detachable arms desk or full-length, swing-away detachable elevating legrests	Prior Authorization Required	Specialized DME	History and Physical to Include the following: diagnosis; abilities and limitations as they relate to the equipment (e.g., degree of independence/ dependence, frequency and nature of the activities the patient performs, duration of medical condition, Past experience if any using similar equipment, Evaluation of upper extremity strength. Include invoice of cost for item.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
E1089	High-strength lightweight wheelchair, fixed-length arms, swing-away detachable footrest	Prior Authorization Required	Medical Necessity	Letter of medical Necessity supporting need for the wheelchair accessory
E1090	High-strength lightweight wheelchair, detachable arms, desk or full-length, swing-away detachable footrests	Prior Authorization Required	Medical Necessity	Letter of medical Necessity supporting need for the wheelchair accessory.
E1100	Semi-reclining wheelchair, fixed full-length arms, swing-away detachable elevating legrests	Prior Authorization Required	Specialized DME	History and Physical to Include the following: diagnosis; abilities and limitations as they relate to the equipment (e.g., degree of independence/ dependence, frequency and nature of the activities the patient performs, duration of medical condition, Past experience if any using similar equipment, Evaluation of upper extremity strength. Include invoice of cost for item.
E1110	Semi-reclining wheelchair, detachable arms (desk or full-length) elevating legrest	Prior Authorization Required	Specialized DME	History and Physical to Include the following: diagnosis; abilities and limitations as they relate to the equipment (e.g., degree of independence/ dependence, frequency and nature of the activities the patient performs, duration of medical condition, Past experience if any using similar equipment, Evaluation of upper extremity strength. Include invoice of cost for item.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
E1160	Wheelchair, fixed full-length arms, swing-away, detachable, elevating legrests	Prior Authorization Required	Cosmetic - Reconstructive	History and Physical to Include the following: diagnosis; abilities and limitations as they relate to the equipment (e.g., degree of independence/ dependence, frequency and nature of the activities the patient performs, duration of medical condition, Past experience if any using similar equipment, Evaluation of upper extremity strength. Include invoice of cost for item.
E1161	Manual adult size wheelchair, includes tilt in space	Prior Authorization Required	Medical Necessity	Submit history and physical to include the following: diagnosis; abilities and limitations as they relate to the equipment (e.g., degree of independence/ dependence, frequency and nature of the activities the patient performs, duration of medical condition, past experience if any using similar equipment, evaluation of upper extremity strength.
E1170	Amputee wheelchair; fixed full-length arms, swing-away, detachable, elevating legrests	Prior Authorization Required	Specialized DME	History and Physical to Include the following: diagnosis; abilities and limitations as they relate to the equipment (e.g., degree of independence/ dependence, frequency and nature of the activities the patient performs, duration of medical condition, Past experience if any using similar equipment, Evaluation of upper extremity strength. Include invoice of cost for item.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
E1171	Amputee wheelchair, fixed full-length arms, without footrests or legrest	Prior Authorization Required	Specialized DME	History and Physical to Include the following: diagnosis; abilities and limitations as they relate to the equipment (e.g., degree of independence/ dependence, frequency and nature of the activities the patient performs, duration of medical condition, Past experience if any using similar equipment, Evaluation of upper extremity strength. Include invoice of cost for item.
E1172	Amputee wheelchair, detachable arms (desk or full-length) without footrests or legrest	Prior Authorization Required	Specialized DME	History and Physical to Include the following: diagnosis; abilities and limitations as they relate to the equipment (e.g., degree of independence/ dependence, frequency and nature of the activities the patient performs, duration of medical condition, Past experience if any using similar equipment, Evaluation of upper extremity strength. Include invoice of cost for item.
E1180	Amputee wheelchair, detachable arms (desk or full-length) swing-away detachable footrests	Pre-Service Review Recommended where description of service is available, otherwise Retrospective Medical Review Required	Specialized DME	History and Physical to Include the following: diagnosis; abilities and limitations as they relate to the equipment (e.g., degree of independence/ dependence, frequency and nature of the activities the patient performs, duration of medical condition, Past experience if any using similar equipment, Evaluation of upper extremity strength. Include invoice of cost for item.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
E1190	Amputee wheelchair, detachable arms (desk or full-length) swing-away detachable elevating legrests	Prior Authorization Required	Specialized DME	History and Physical to Include the following: diagnosis; abilities and limitations as they relate to the equipment (e.g., degree of independence/ dependence, frequency and nature of the activities the patient performs, duration of medical condition, Past experience if any using similar equipment, Evaluation of upper extremity strength. Include invoice of cost for item.
E1195	Heavy duty wheelchair; fixed full-length arms, swing-away, detachable, elevating legrests	Prior Authorization Required	Specialized DME	History and Physical to Include the following: diagnosis; abilities and limitations as they relate to the equipment (e.g., degree of independence/ dependence, frequency and nature of the activities the patient performs, duration of medical condition, Past experience if any using similar equipment, Evaluation of upper extremity strength. Include invoice of cost for item.
E1200	Amputee wheelchair; fixed full-length arms, swing-away, detachable footrests	Prior Authorization Required	Specialized DME	History and Physical to Include the following: diagnosis; abilities and limitations as they relate to the equipment (e.g., degree of independence/ dependence, frequency and nature of the activities the patient performs, duration of medical condition, Past experience if any using similar equipment, Evaluation of upper extremity strength. Include invoice of cost for item.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
E1220	Wheelchair; specially sized or constructed, (indicate brand name, model number, if any) and justification	Prior Authorization Required	Medical Necessity	Letter of medical Necessity supporting need for the wheelchair accessory.
E1221	Wheelchair with fixed arm, footrests	Prior Authorization Required	Specialized DME	History and Physical to Include the following: diagnosis; abilities and limitations as they relate to the equipment (e.g., degree of independence/ dependence, frequency and nature of the activities the patient performs, duration of medical condition, Past experience if any using similar equipment, Evaluation of upper extremity strength. Include invoice of cost for item.
E1223	Wheelchair with detachable arms, footrests	Prior Authorization Required	Specialized DME	History and Physical to Include the following: diagnosis; abilities and limitations as they relate to the equipment (e.g., degree of independence/ dependence, frequency and nature of the activities the patient performs, duration of medical condition, Past experience if any using similar equipment, Evaluation of upper extremity strength. Include invoice of cost for item.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
E1224	Wheelchair with detachable arms, elevating legrests	Prior Authorization Required	Specialized DME	History and Physical to Include the following: diagnosis; abilities and limitations as they relate to the equipment (e.g., degree of independence/ dependence, frequency and nature of the activities the patient performs, duration of medical condition, Past experience if any using similar equipment, Evaluation of upper extremity strength. Include invoice of cost for item.
E1229	Wheelchair, pediatric size, not otherwise specified	Prior Authorization Required	Medical Necessity	Letter of medical Necessity supporting need for the wheelchair accessory.
E1230	Power operated vehicle (three- or four-wheel nonhighway), specify brand name and model number	Prior Authorization Required	Medical Necessity	History and Physical to Include the following: diagnosis; abilities and limitations as they relate to the equipment (e.g., degree of independence/ dependence, frequency and nature of the activities the patient performs, duration of medical condition, Past experience if any using similar equipment, Evaluation of upper extremity strength, Documented inability to propel a manual chair.
E1231	Wheelchair, pediatric size, tilt-in-space, rigid, adjustable, with seating system	Prior Authorization Required	Medical Necessity	Submit history and physical to include the following: diagnosis; abilities and limitations as they relate to the equipment (e.g., degree of independence/ dependence, frequency and nature of the activities the patient performs, duration of medical condition, past experience if any using similar equipment, evaluation of upper extremity strength.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
E1232	Wheelchair; Pediatric size, tilt-in-space, folding, adjustable, with seating system	Prior Authorization Required	Medical Necessity	Submit history and physical to include the following: diagnosis; abilities and limitations as they relate to the equipment (e.g., degree of independence/ dependence, frequency and nature of the activities the patient performs, duration of medical condition, past experience if any using similar equipment, evaluation of upper extremity strength.
E1233	Pediatric size, tilt-in-space, rigid, adjustable, without seating system	Prior Authorization Required	Medical Necessity	Submit history and physical to include the following: diagnosis; abilities and limitations as they relate to the equipment (e.g., degree of independence/ dependence, frequency and nature of the activities the patient performs, duration of medical condition, past experience if any using similar equipment, evaluation of upper extremity strength.
E1234	Pediatric size, tilt-in-space, folding adjustable with seating system	Prior Authorization Required	Medical Necessity	Submit history and physical to include the following: diagnosis; abilities and limitations as they relate to the equipment (e.g., degree of independence/ dependence, frequency and nature of the activities the patient performs, duration of medical condition, past experience if any using similar equipment, evaluation of upper extremity strength.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
E1235	Pediatric size, folding, adjustable, with seating system	Prior Authorization Required	Specialized DME	History and Physical to Include the following: diagnosis; abilities and limitations as they relate to the equipment (e.g., degree of independence/ dependence, frequency and nature of the activities the patient performs, duration of medical condition, Past experience if any using similar equipment, Evaluation of upper extremity strength. Include invoice of cost for item.
E1236	Wheelchair, pediatric size, folding, adjustable, with seating system	Prior Authorization Required	Specialized DME	History and Physical to Include the following: diagnosis; abilities and limitations as they relate to the equipment (e.g., degree of independence/ dependence, frequency and nature of the activities the patient performs, duration of medical condition, Past experience if any using similar equipment, Evaluation of upper extremity strength. Include invoice of cost for item.
E1237	Pediatric size, rigid, adjustable, without seating system	Prior Authorization Required	Specialized DME	History and Physical to Include the following: diagnosis; abilities and limitations as they relate to the equipment (e.g., degree of independence/ dependence, frequency and nature of the activities the patient performs, duration of medical condition, Past experience if any using similar equipment, Evaluation of upper extremity strength. Include invoice of cost for item.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
E1238	Pediatric size, folding, adjustable, without seating system	Prior Authorization Required	Specialized DME	Letter of medical necessity containing the following information: Anticipated length of time patient will require the equipment, Description of medical condition requiring use of this equipment including mobility status, Surgical procedure description and Date if any performed.Include invoice of cost for item.
E1240	Lightweight wheelchair, detachable arms, (desk or full-length) swing-away detachable, elevating legrest	Prior Authorization Required	Specialized DME	History and Physical to Include the following: diagnosis; abilities and limitations as they relate to the equipment (e.g., degree of independence/ dependence, frequency and nature of the activities the patient performs, duration of medical condition, Past experience if any using similar equipment, Evaluation of upper extremity strength. Include invoice of cost for item.
E1250	Lightweight wheelchair, fixed full-length arms, swing-away detachable footrest	Prior Authorization Required	Specialized DME	History and Physical to Include the following: diagnosis; abilities and limitations as they relate to the equipment (e.g., degree of independence/ dependence, frequency and nature of the activities the patient performs, duration of medical condition, Past experience if any using similar equipment, Evaluation of upper extremity strength. Include invoice of cost for item.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
E1260	Lightweight wheelchair, detachable arms (desk or full-length) swing-away detachable footrest	Prior Authorization Required	Specialized DME	History and Physical to Include the following: diagnosis; abilities and limitations as they relate to the equipment (e.g., degree of independence/ dependence, frequency and nature of the activities the patient performs, duration of medical condition, Past experience if any using similar equipment, Evaluation of upper extremity strength. Include invoice of cost for item.
E1270	Lightweight wheelchair, fixed full-length arms, swing-away detachable elevating legrests	Prior Authorization Required	Specialized DME	History and Physical to Include the following: diagnosis; abilities and limitations as they relate to the equipment (e.g., degree of independence/ dependence, frequency and nature of the activities the patient performs, duration of medical condition, Past experience if any using similar equipment, Evaluation of upper extremity strength. Include invoice of cost for item.
E1280	Heavy duty wheelchair; detachable arms, desk or full-length, elevating legrests	Prior Authorization Required	Specialized DME	History and Physical to Include the following: diagnosis; abilities and limitations as they relate to the equipment (e.g., degree of independence/ dependence, frequency and nature of the activities the patient performs, duration of medical condition, Past experience if any using similar equipment, Evaluation of upper extremity strength. Include invoice of cost for item.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
E1285	Heavy-duty wheelchair, fixed full-length arms, swing-away detachable footrest	Prior Authorization Required	Specialized DME	History and Physical to Include the following: diagnosis; abilities and limitations as they relate to the equipment (e.g., degree of independence/ dependence, frequency and nature of the activities the patient performs, duration of medical condition, Past experience if any using similar equipment, Evaluation of upper extremity strength. Include invoice of cost for item.
E1290	Heavy-duty wheelchair, detachable arms (desk or full-length) swing-away detachable footrest	Prior Authorization Required	Specialized DME	History and Physical to Include the following: diagnosis; abilities and limitations as they relate to the equipment (e.g., degree of independence/ dependence, frequency and nature of the activities the patient performs, duration of medical condition, Past experience if any using similar equipment, Evaluation of upper extremity strength. Include invoice of cost for item.
E1295	Heavy-duty wheelchair, fixed full-length arms, elevating legrest	Prior Authorization Required	Specialized DME	History and Physical to Include the following: diagnosis; abilities and limitations as they relate to the equipment (e.g., degree of independence/ dependence, frequency and nature of the activities the patient performs, duration of medical condition, Past experience if any using similar equipment, Evaluation of upper extremity strength. Include invoice of cost for item.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
E1300	Whirlpool, portable (overtub type)	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
E1301	Whirlpool tub, walk-in, portable	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
E1310	Whirlpool, nonportable (built-in type)	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
E1399	Durable medical equipment, miscellaneous	Medical necessity review will be performed upon claims submission with supporting documentation.	Medical Necessity	Upon claims submission Medical necessity review will be performed. Submit documentation to describe the services. Include a copy of the manufacturer cost invoice. From the ordering MD, request a letter of medical necessity for the item provided.
E1570	Adjustable chair, for ESRD patients	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
E1902	Communication board, nonelectronic augmentative or alternative communication device	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
E1905	Virtual reality cognitive behavioral therapy device (CBT), including pre-programmed therapy software	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
E2001	Suction pump, home model, portable or stationary, electric, any type, for use with external urine and/or fecal management system	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
E2227	Manual wheelchair accessory, gear reduction drive wheel, each	Prior Authorization Required	Specialized DME	Letter of medical Necessity supporting need for the wheelchair accessory. Include invoice of cost for item.
E2230	Manual wheelchair accessory, manual standing system	Prior Authorization Required	Medical Necessity	Letter of medical Necessity supporting need for the wheelchair accessory.
E2292	Seat, planar, for pediatric size wheelchair including fixed attaching hardware	Prior Authorization Required	Medical Necessity	Letter of medical Necessity supporting need for the wheelchair accessory.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
E2295	Manual wheelchair accessory, for pediatric size wheelchair, dynamic seating frame, allows coordinated movement of multiple positioning features	Prior Authorization Required	Medical Necessity	Letter of medical Necessity supporting need for the wheelchair accessory.
E2301	Power wheelchair accessory, power standing system	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
E2331	Power wheelchair accessory, attendant control, proportional, including all related electronics and fixed mounting hardware	Prior Authorization Required	Medical Necessity	Letter of medical Necessity supporting need for the wheelchair accessory.
E2341	Power wheelchair accessory, nonstandard seat frame width, 24-27 in	Prior Authorization Required	Medical Necessity	Letter of medical Necessity supporting need for the wheelchair accessory.
E2342	Non-standard seat frame depth, 20 or 21 inches	Prior Authorization Required	Medical Necessity	Letter of medical Necessity supporting need for the wheelchair accessory.
E2343	Power wheelchair accessory, nonstandard seat frame depth, 22-25 in	Prior Authorization Required	Medical Necessity	Letter of medical Necessity supporting need for the wheelchair accessory.
E2351	Power wheelchair accessory, electronic interface to operate speech generating device using power wheelchair control interface	Prior Authorization Required	Medical Necessity	Letter of medical Necessity supporting need for the wheelchair accessory.
E2358	Power wheelchair accessory, group 34 nonsealed lead acid battery, each	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
E2360	Power wheelchair accessory, 22 NF nonsealed lead acid battery, each	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
E2362	Power wheelchair accessory, group 24 nonsealed lead acid battery, each	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
E2364	Power wheelchair accessory, U-1 nonsealed lead acid battery, each	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
E2367	Power wheelchair accessory, battery charger, dual mode, for use with either battery type, sealed or nonsealed, each	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
E2372	Power wheelchair accessory, group 27 nonsealed lead acid battery, each	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
E2383	Power wheelchair accessory, insert for pneumatic drive wheel tire (removable), any type, any size, replacement only, each	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
E2398	Wheelchair accessory, dynamic positioning hardware for back	Prior Authorization Required	Medical Necessity	Letter of medical Necessity supporting need for the wheelchair accessory.
E2609	Custom fabricated wheelchair seat cushion, any size	Prior Authorization Required	Medical Necessity	Letter of medical Necessity supporting need for the wheelchair accessory. Include invoice of cost for item.
E2610	Wheelchair seat cushion, powered	Prior Authorization Required	Medical Necessity	Letter of medical Necessity supporting need for the wheelchair accessory.
E2617	Custom fabricated wheelchair back cushion, any size, includes any type mounting hardware	Prior Authorization Required	Medical Necessity	Letter of medical Necessity supporting need for the wheelchair accessory
E2620	Positioning wheelchair back cushion, planar back with lateral supports, width less than 22 in., any height, including any type mounting hardware	Prior Authorization Required	Medical Necessity	Letter of medical Necessity supporting need for the wheelchair accessory.
E2621	Positioning wheelchair back cushion, planar back with lateral supports, width 22 in or greater, any height, including any type mounting hardware	Prior Authorization Required	Medical Necessity	Letter of medical Necessity supporting need for the wheelchair accessory.
E2622	Skin protection wheelchair seat cushion, adjustable, width less than 22 in, any depth	Prior Authorization Required	Medical Necessity	Letter of medical Necessity supporting need for the wheelchair accessory.
E2623	Skin protection wheelchair seat cushion, adjustable, width 22 in or greater, any depth	Prior Authorization Required	Medical Necessity	Letter of medical Necessity supporting need for the wheelchair accessory. Include invoice of cost for item.
E3000	Speech volume modulation system, any type, including all components and accessories	Possible Denial; Medical Records Optional	Investigative	Documentation optional.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
E3200	Gait modulation system, rhythmic auditory stimulation, including restricted therapy software, all components and accessories, prescription only	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
G0019	Community health integration services performed by certified or trained auxiliary personnel, including a community health worker, under the direction of a physician, 60 minutes PCM	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
G0022	Community health integration services, each additional 30 minutes per calendar month	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
G0023	Principal illness navigation services by certified or trained auxiliary personnel under the direction of a physician or other practitioner, including a patient navigator; 60 minutes PCM	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
G0024	Principal illness navigation services, additional 30 minutes per calendar month	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
G0136	Administration of a standardized, evidence-based social determinants of health risk assessment tool. 5-15 minutes	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
G0138	Intravenous infusion of cipaglucosidase alfa-atga, including provider/supplier acquisition and clinical supervision of oral administration of miglustat in preparation of receipt of cipaglucosidase alfa-atga	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.

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G0140	Principal illness navigation - peer support by certified or trained auxiliary personnel under the direction of a physician or other practitioner; 60 minutes per calendar month	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
G0146	Principal illness navigation - peer support, additional 30 minutes per calendar month	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
G0176	Activity therapy, such as music, dance, art or play therapies not for recreation, related to the care and treatment of patient's disabling mental health problems, per session (45 minutes or more)	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
G0219	PET imaging whole body; melanoma for noncovered indications	Prior Authorization Required	Advanced Imaging	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
G0252	PET imaging, full and partial-ring PET scanners only, for initial diagnosis of breast cancer and/or surgical planning for breast cancer (e.g., initial staging of axillary lymph nodes)	Prior Authorization Required	Advanced Imaging	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
G0259	Injection procedure for sacroiliac joint; arthrography	Pre-Service Review Required	Investigative	Submit history and physical, documentation of medical necessity and procedure report.
G0277	Hyperbaric oxygen under pressure, full body chamber, per 30 minute interval	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity and procedure report.

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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 of care	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
G0282	Electrical stimulation, (unattended), to one or more areas, for wound care other than described in G0281	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
G0283	Electrical stimulation (unattended), to one or more areas for indication(s) other than wound care, as part of a therapy plan of care	Retrospective Review	Outpatient Rehabilitation	For Alaska plans: After initial visit, submit online review at www.evicore.com. For Washington plans: After the first 6 treatment visits in an episode of care, submit online review at www.evicore.com.
G0293	Noncovered surgical procedure(s) using conscious sedation, regional, general, or spinal anesthesia in a Medicare qualifying clinical trial, per day	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
G0294	Noncovered procedure(s) using either no anesthesia or local anesthesia only, in a Medicare qualifying clinical trial, per day	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
G0295	Electromagnetic therapy, to one or more areas, for wound care other than described in G0329 or for other uses	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
G0329	Electromagnetic therapy, to one or more areas for chronic stage III or IV pressure ulcers, arterial ulcers, diabetic ulcers and venous ulcers not demonstrating measurable signs of healing after 30 days of conventional care as part of a therapy plan of care	Possible Denial; Medical Records Optional	Investigative	Documentation optional.

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G0330	Facility services for dental rehabilitation procedure(s) performed on a patient who requires monitored anesthesia (e.g., general, intravenous sedation (monitored anesthesia care) and use of an operating room	Prior Authorization Required	Medical Necessity	MDs fax to IHM at 800-843-1114; DDS or DMDs: Complete the Dental Prior Authorization form found at: https://www.premera.com/documents/030000.pdf and FAX completed form to 425-918-5956 for review.
G0339	Image guided robotic linear accelerator-based stereotactic radiosurgery, complete course of therapy in one session, or first session of fractionated treatment	Prior Authorization Required	Radiation Oncology	No review for non-cancer diagnoses. FOR CANCER DIAGNOSES ONLY: Submit online review with Carelon at www.providerportal.com. For prior authorization include history and physical, results of previous diagnostics procedure report.
G0340	Image guided robotic linear accelerator-based stereotactic radiosurgery, delivery including collimator changes and custom plugging, fractionated treatment, all lesions, per session, second through fifth sessions, maximum 5 sessions per course of treatment	Prior Authorization Required	Radiation Oncology	No review for non-cancer diagnoses. FOR CANCER DIAGNOSES ONLY: Submit online review with Carelon at www.providerportal.com. For prior authorization include history and physical, results of previous diagnostics procedure report.
G0341	Percutaneous islet cell transplant, includes portal vein catheterization and infusion	Prior Authorization Required	Medical Necessity	Submit Transplant evaluation and facility acceptance letter
G0342	Laparoscopy for islet cell transplant, includes portal vein catheterization and infusion	Prior Authorization Required	Medical Necessity	Submit Transplant evaluation and facility acceptance letter
G0343	Laparotomy for islet cell transplant, includes portal vein catheterization and infusion	Prior Authorization Required	Medical Necessity	Submit Transplant evaluation and facility acceptance letter

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G0428	Collagen meniscus implant procedure for filling meniscal defects (e.g., CMI, collagen scaffold, Menaflex)	Pre-Service Review Required	Investigative	Pre Operative Evaluation, History and Physical with description of defect including whether it is full thickness, size, if there has been prior arthroscopic/surgical repair, and Operative report
G0453	Continuous intraoperative neurophysiology monitoring, from outside the operating room (remote or nearby), per patient, (attention directed exclusively to one patient) each 15 minutes (list in addition to primary procedure)	Pre-Service Review Required	Medical Necessity	Submit History and Physical, documentation of medical necessity, procedure report
G0458	Low dose rate (LDR) prostate brachytherapy services, composite rate	Prior Authorization Required	Radiation Oncology	No review for non-cancer diagnoses. FOR CANCER DIAGNOSES ONLY: Submit online review with Carelon at www.providerportal.com. For prior authorization include history and physical, results of previous diagnostics procedure report.
G0460	Autologous platelet rich plasma for chronic wounds/ulcers, including phlebotomy, centrifugation, and all other preparatory procedures, administration and dressings, per treatment	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
G0552	Supply of digital mental health treatment device and initial education and onboarding, per course of treatment that augments a behavioral therapy plan	Possible Denial; Medical Records Optional	Investigative	Documentation optional.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
G0553	First 20 minutes of monthly treatment management services directly related to the patient's therapeutic use of the digital mental health treatment (dmht) device that augments a behavioral therapy plan, physician/other qualified health care professional time reviewing information related to the use of the dmht device, including patient observations and patient specific inputs in a calendar month and requiring at least one interactive communication with the patient/caregiver during the calendar month	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
G0554	Each additional 20 minutes of monthly treatment management services directly related to the patient's therapeutic use of the digital mental health treatment (dmht) device that augments a behavioral therapy plan, physician/other qualified health care professional time reviewing data generated from the dmht device from patient observations and patient specific inputs in a calendar month and requiring at least one interactive communication with the patient/caregiver during the calendar month	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
G0555	Provision of replacement patient electronics system (e.g., system pillow, handheld reader) for home pulmonary artery pressure monitoring	Possible Denial; Medical Records Optional	Investigative	Documentation optional.

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G0562	Therapeutic radiology simulation-aided field setting; complex, including acquisition of PET and CT imaging data required for radiopharmaceutical-directed radiation therapy treatment planning (i.e., modeling)	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
G0563	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	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
G2082	Office or other outpatient visit for the evaluation and management of an established patient that requires the supervision of a physician or other qualified health care professional and provision of up to 56 mg of esketamine nasal self administration, includes 2 hours post administration observation	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity and procedure report.
G2083	Office or other outpatient visit for the evaluation and management of an established patient that requires the supervision of a physician or other qualified health care professional and provision of greater than 56 mg esketamine nasal self administration, includes 2 hours post administration observation	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity and procedure report.

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G6001	Ultrasonic guidance for placement of radiation therapy fields	Prior Authorization Required	Radiation Oncology	No review for non-cancer diagnoses. FOR CANCER DIAGNOSES ONLY: Submit online review with Carelon at www.providerportal.com. For prior authorization include history and physical, results of previous diagnostics procedure report.
G6002	Stereoscopic x-ray guidance for localization of target volume for the delivery of radiation therapy	Prior Authorization Required	Radiation Oncology	No review for non-cancer diagnoses. FOR CANCER DIAGNOSES ONLY: Submit online review with Carelon at www.providerportal.com. For prior authorization include history and physical, results of previous diagnostics procedure report.
G6003	Radiation treatment delivery, single treatment area, single port or parallel opposed ports, simple blocks or no blocks: up to 5 mev	Prior Authorization Required	Radiation Oncology	No review for non-cancer diagnoses. REVIEWED ONLY for BONE METs, FEMALE BREAST, MALE BREAST, NON-SMALL LUNG CELL CANCER or PROSTATE CANCER DIAGNOSES: Submit online review with Carelon at www.providerportal.com. For prior authorization include history and physical, results of previous diagnostics procedure report.
G6004	Radiation treatment delivery, single treatment area, single port or parallel opposed ports, simple blocks or no blocks: 6-10 mev	Prior Authorization Required	Radiation Oncology	No review for non-cancer diagnoses. REVIEWED ONLY for BONE METs, FEMALE BREAST, MALE BREAST, NON-SMALL LUNG CELL CANCER or PROSTATE CANCER DIAGNOSES: Submit online review with Carelon at www.providerportal.com. For prior authorization include history and physical, results of previous diagnostics procedure report.

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G6005	Radiation treatment delivery, single treatment area, single port or parallel opposed ports, simple blocks or no blocks: 11-19 mev	Prior Authorization Required	Radiation Oncology	No review for non-cancer diagnoses. REVIEWED ONLY for BONE METs, FEMALE BREAST, MALE BREAST, NON-SMALL LUNG CELL CANCER or PROSTATE CANCER DIAGNOSES: Submit online review with Carelon at www.providerportal.com. For prior authorization include history and physical, results of previous diagnostics procedure report.
G6006	Radiation treatment delivery, single treatment area, single port or parallel opposed ports, simple blocks or no blocks: 20 mev or greater	Prior Authorization Required	Radiation Oncology	No review for non-cancer diagnoses. REVIEWED ONLY for BONE METs, FEMALE BREAST, MALE BREAST, NON-SMALL LUNG CELL CANCER or PROSTATE CANCER DIAGNOSES: Submit online review with Carelon at www.providerportal.com. For prior authorization include history and physical, results of previous diagnostics procedure report.
G6007	Radiation treatment delivery, 2 separate treatment areas, 3 or more ports on a single treatment area, use of multiple blocks: up to 5 mev	Prior Authorization Required	Radiation Oncology	No review for non-cancer diagnoses. REVIEWED ONLY for BONE METs, FEMALE BREAST, MALE BREAST, NON-SMALL LUNG CELL CANCER or PROSTATE CANCER DIAGNOSES: Submit online review with Carelon at www.providerportal.com. For prior authorization include history and physical, results of previous diagnostics procedure report.

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G6008	Radiation treatment delivery, 2 separate treatment areas, 3 or more ports on a single treatment area, use of multiple blocks: 6-10 mev	Prior Authorization Required	Radiation Oncology	No review for non-cancer diagnoses. REVIEWED ONLY for BONE METs, FEMALE BREAST, MALE BREAST, NON-SMALL LUNG CELL CANCER or PROSTATE CANCER DIAGNOSES: Submit online review with Carelon at www.providerportal.com. For prior authorization include history and physical, results of previous diagnostics procedure report.
G6009	Radiation treatment delivery, 2 separate treatment areas, 3 or more ports on a single treatment area, use of multiple blocks: 11-19 mev	Prior Authorization Required	Radiation Oncology	No review for non-cancer diagnoses. REVIEWED ONLY for BONE METs, FEMALE BREAST, MALE BREAST, NON-SMALL LUNG CELL CANCER or PROSTATE CANCER DIAGNOSES: Submit online review with Carelon at www.providerportal.com. For prior authorization include history and physical, results of previous diagnostics procedure report.
G6010	Radiation treatment delivery, 2 separate treatment areas, 3 or more ports on a single treatment area, use of multiple blocks: 20 mev or greater	Prior Authorization Required	Radiation Oncology	No review for non-cancer diagnoses. REVIEWED ONLY for BONE METs, FEMALE BREAST, MALE BREAST, NON-SMALL LUNG CELL CANCER or PROSTATE CANCER DIAGNOSES: Submit online review with Carelon at www.providerportal.com. For prior authorization include history and physical, results of previous diagnostics procedure report.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
G6011	Radiation treatment delivery, 3 or more separate treatment areas, custom blocking, tangential ports, wedges, rotational beam, compensators, electron beam; up to 5 mev	Prior Authorization Required	Radiation Oncology	No review for non-cancer diagnoses. REVIEWED ONLY for BONE METs, FEMALE BREAST, MALE BREAST, NON-SMALL LUNG CELL CANCER or PROSTATE CANCER DIAGNOSES: Submit online review with Carelon at www.providerportal.com. For prior authorization include history and physical, results of previous diagnostics procedure report.
G6012	Radiation treatment delivery, 3 or more separate treatment areas, custom blocking, tangential ports, wedges, rotational beam, compensators, electron beam; 6-10 mev	Prior Authorization Required	Radiation Oncology	No review for non-cancer diagnoses. REVIEWED ONLY for BONE METs, FEMALE BREAST, MALE BREAST, NON-SMALL LUNG CELL CANCER or PROSTATE CANCER DIAGNOSES: Submit online review with Carelon at www.providerportal.com. For prior authorization include history and physical, results of previous diagnostics procedure report.
G6013	Radiation treatment delivery, 3 or more separate treatment areas, custom blocking, tangential ports, wedges, rotational beam, compensators, electron beam; 11-19 mev	Prior Authorization Required	Radiation Oncology	No review for non-cancer diagnoses. FOR CANCER DIAGNOSES ONLY: Submit online review with Carelon at www.providerportal.com. For prior authorization include history and physical, results of previous diagnostics procedure report.

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G6014	Radiation treatment delivery, 3 or more separate treatment areas, custom blocking, tangential ports, wedges, rotational beam, compensators, electron beam; 20 mev or greater	Prior Authorization Required	Radiation Oncology	No review for non-cancer diagnoses. REVIEWED ONLY for BONE METs, FEMALE BREAST, MALE BREAST, NON-SMALL LUNG CELL CANCER or PROSTATE CANCER DIAGNOSES: Submit online review with Carelon at www.providerportal.com. For prior authorization include history and physical, results of previous diagnostics procedure report.
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 Required	Radiation Oncology	No review for non-cancer diagnoses. FOR CANCER DIAGNOSES ONLY: Submit online review with Carelon at www.providerportal.com. For prior authorization include history and physical, results of previous diagnostics procedure report.
G6016	Compensator-based beam modulation treatment delivery of inverse planned treatment using 3 or more high resolution (milled or cast) compensator, convergent beam modulated fields, per treatment session	Prior Authorization Required	Radiation Oncology	No review for non-cancer diagnoses. FOR CANCER DIAGNOSES ONLY: Submit online review with Carelon at www.providerportal.com. For prior authorization include history and physical, results of previous diagnostics procedure report.
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 Required	Radiation Oncology	No review for non-cancer diagnoses. FOR CANCER DIAGNOSES ONLY: Submit online review with Carelon at www.providerportal.com. For prior authorization include history and physical, results of previous diagnostics procedure report.
G9012	Other specified case management service not elsewhere classified	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.

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G9143	Warfarin responsiveness testing by genetic technique using any method, any number of specimen(s)	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
H0002	Behavioral health screening to determine eligibility for admission to treatment program	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
H0006	Alcohol and/or drug services; case management	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
H0008	Alcohol and/or drug services; subacute detoxification (hospital inpatient)	Pre-Service Review Required	Medical Necessity	Submit history and physical, admission evaluation, and documentation of medical necessity
H0009	Alcohol and/or drug services; acute detoxification (hospital inpatient)	Pre-Service Review Required	Medical Necessity	Submit history and physical, admission evaluation, and documentation of medical necessity.
H0010	Alcohol and/or drug services; subacute detoxification (residential addiction program inpatient)	Pre-Service Review Required	Medical Necessity	Submit history and physical, admission evaluation, and documentation of medical necessity.
H0011	Alcohol and/or drug services; acute detoxification (residential addiction program inpatient)	Pre-Service Review Required	Medical Necessity	Submit history and physical, admission evaluation, and documentation of medical necessity.
H0017	Behavioral health; residential (hospital residential treatment program), without room and board, per diem	Pre-Service Review Required	Medical Necessity	Submit history, admission evaluation, any treatment sessions to date, and documentation of medical necessity.
H0018	Behavioral health; short-term residential (nonhospital residential treatment program), without room and board, per diem	Pre-Service Review Required	Medical Necessity	Submit history, admission evaluation, any treatment sessions to date, and documentation of medical necessity.
H0019	Behavioral health; long-term residential (nonmedical, nonacute care in a residential treatment program where stay is typically longer than 30 days), without room and board, per diem	Pre-Service Review Required	Medical Necessity	Submit history, admission evaluation, any treatment sessions to date, and documentation of medical necessity.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
H0021	Alcohol and/or drug training service (for staff and personnel not employed by providers)	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
H0022	Alcohol and/or drug intervention service (planned facilitation)	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
H0023	Behavioral health outreach service (planned approach to reach a targeted population)	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
H0024	Behavioral health prevention information dissemination service (one-way direct or nondirect contact with service audiences to affect knowledge and attitude)	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
H0025	Behavioral health prevention education service (delivery of services with target population to affect knowledge, attitude and/or behavior)	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
H0026	Alcohol and/or drug prevention process service, community-based (delivery of services to develop skills of impactors)	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
H0027	Alcohol and/or drug prevention environmental service (broad range of external activities geared toward modifying systems in order to mainstream prevention through policy and law)	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
H0028	Alcohol and/or drug prevention problem identification and referral service (e.g., student assistance and employee assistance programs), does not include assessment	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
H0029	Alcohol and/or drug prevention alternatives service (services for populations that exclude alcohol and other drug use e.g., alcohol free social events)	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
H0030	Behavioral health hotline service	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
H0034	Medication training and support, per 15 minutes	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
H0037	Community psychiatric supportive treatment program, per diem	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
H0038	Self-help/peer services, per 15 minutes	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
H0039	Assertive community treatment, face-to-face, per 15 minutes	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
H0040	Assertive community treatment program, per diem	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
H0041	Foster care, child, nontherapeutic, per diem	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
H0042	Foster care, child, nontherapeutic, per month	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
H0043	Supported housing, per diem	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
H0044	Supported housing, per month	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
H0045	Respite care services, not in the home, per diem	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
H0046	Mental health services, not otherwise specified	Medical necessity review will be performed upon claims submission with supporting documentation.	Medical Necessity	Review required at claims submission; submit description of procedure with supporting documentation (including operative report if surgical) only for the date of service performed.

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H0047	Alcohol and/or other drug abuse services, not otherwise specified	Medical necessity review will be performed upon claims submission with supporting documentation.	Medical Necessity	Review required at claims submission; submit description of procedure with supporting documentation (including operative report if surgical) only for the date of service performed.
H0048	Alcohol and/or other drug testing: collection and handling only, specimens other than blood	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
H0051	Traditional healing service	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
H1010	Nonmedical family planning education, per session	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
H1011	Family assessment by licensed behavioral health professional for state defined purposes	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
H2012	Behavioral Health day treatment per hour	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
H2015	Comprehensive community support services, per 15 minutes	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
H2016	Comprehensive community support services, per diem	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
H2017	Psychosocial rehabilitation services, per 15 minutes	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
H2018	Psychosocial rehabilitation services, per diem	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
H2020	Therapeutic behavioral services per diem	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
H2021	Community-based wrap-around services, per 15 minutes	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
H2022	Community-based wrap-around services, per diem	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
H2023	Supported employment, per 15 minutes	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.

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H2024	Supported employment, per diem	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
H2025	Ongoing support to maintain employment, per 15 minutes	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
H2026	Ongoing support to maintain employment, per diem	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
H2027	Psychoeducational service, per 15 minutes	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
H2029	Sexual offender treatment services per diem	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
H2030	Mental health clubhouse services, per 15 minutes	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
H2031	Mental health clubhouse services, per diem	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
H2032	Activity therapy, per 15 minutes	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
H2034	Alcohol and/or drug abuse halfway house services, per diem	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
H2035	Alcohol and/or other drug treatment program per hour	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
H2037	Developmental delay prevention activities, dependent child of client, per 15 minutes	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
H2038	Skills training and development, per diem	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
H2040	Coordinated specialty care, team-based, for first episode psychosis, per month	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
H2041	Coordinated specialty care, team-based, for first episode psychosis, per encounter	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
J0129	Injection, abatacept, 10 mg	Prior Authorization Required	Medical necessity including site of service	The IV form of this drug requires review for site of service administration in addition to prior authorization/medical necessity review. Submit history and physical and recent lab work.
J0139	Injection, adalimumab, 1 mg	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
J0172	Injection, aducanumab-avwa, 2 mg	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
J0174	Inj, lecanemab-irmb, 1 mg	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
J0175	Injection, donanemab-azbt, 2 mg	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
J0177	Injection, aflibercept HD, 1 mg	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
J0178	Injection, aflibercept, 1 mg (Eylea)	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
J0179	Injection, brolucizumab-dbll, 1 mg	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
J0180	Injection, agalsidase beta, 1 mg	Prior Authorization Required	Medical necessity including site of service	This drug requires review for site of service administration in addition to review for prior authorization/medical necessity. Submit history and physical and recent lab work.
J0202	Injection, Alemtuzumab, 1 MG	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, treatment plan
J0217	Injection, velmanase alfa-tycv, 1 mg	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
J0218	Injection, Olipudase alfa-rpcp, 1 mg	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
J0219	Injection, avalglucosidase alfa-ngpt, 4 mg	Prior Authorization Required	Medical necessity including site of service	This drug requires review for site of service administration in addition to review for prior authorization/medical necessity. Submit history and physical and recent lab work.
J0221	Injection, alglucosidase alfa, (Lumizyme), 10 mg	Prior Authorization Required	Medical necessity including site of service	This drug requires review for site of service administration in addition to review for prior authorization/medical necessity. Submit history and physical and recent lab work.
J0222	Injection, patisiran, 0.1 mg	Prior Authorization Required	Medical Necessity	Submit History and Physical, documentation of medical necessity, treatment plan
J0223	Injection, givosiran, 0.5 mg	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
J0224	Injection, lumasiran, 0.5 mg	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity and treatment plan.
J0225	Injection, vutrisiran, 1 mg	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
J0256	Injection, alpha 1 proteinase inhibitor (human), not otherwise specified, 10 mg	Prior Authorization Required	Medical necessity including site of service	Submit recent history and physical, plan of care, and documentation of medical necessity including for site of service.
J0257	Injection, alpha 1 proteinase inhibitor (human), (GLASSIA), 10 mg	Prior Authorization Required	Medical Necessity	Submit recent history and physical, plan of care, and documentation of medical necessity including for site of service.
J0485	Injection, belatacept, 1 mg	Prior Authorization Required	Medical necessity including site of service	This drug requires review for site of service administration in addition to review for prior authorization/medical necessity. Submit history and physical and recent lab work.

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J0490	Injection, belimumab, 10 mg	Prior Authorization Required	Medical necessity including site of service	This drug requires review for site of service administration in addition to review for prior authorization/medical necessity. Submit history and physical and recent lab work.
J0491	Injection, anifrolumab-fnia, 1 mg	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
J0517	Injection, benralizumab, 1 mg	Prior Authorization Required	Medical Necessity	History and Physical, including prior treatments and proposed treatment plan
J0565	Injection, bezlotoxumab, 10 mg	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
J0567	Injection, cerliponase alfa, 1 mg	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
J0584	Injection, burosumab-twza 1 mg	Prior Authorization Required	Medical necessity including site of service	This drug requires review for site of service administration in addition to review for prior authorization/medical necessity. Submit history and physical and recent lab work.
J0585	Injection, onabotulinumtoxinA, 1 unit	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
J0586	Injection, abobotulinumtoxinA, 5 units	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
J0587	Injection, rimabotulinumtoxinB, 100 units	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
J0588	Injection, incobotulinumtoxinA, 1 unit	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
J0589	Injection, Daxibotulinumtoxina-lanm, 1 unit	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
J0591	Injection, deoxycholic acid, 1 mg	Possible Denial; Medical Records Optional	Cosmetic	Clinical notes from doctor's office related to this condition and treatment

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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 Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
J0596	Injection, C1 esterase inhibitor (recombinant), Ruconest, 10 units	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
J0597	Injection, C-1 esterase inhibitor (human), Berinert, 10 units	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
J0598	Injection, C-1 esterase inhibitor (human), Cinryze, 10 units	Prior Authorization Required	Medical necessity including site of service	This drug requires review for site of service administration in addition to review for prior authorization/medical necessity. Submit history and physical and recent lab work.
J0599	Injection, C-1 esterase inhibitor (human), (Haegarda), 10 units	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
J0638	Injection, canakinumab, 1 mg	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
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 Required	Medical Necessity	History and Physical, clinical notes related to a condition being treated, documentation of previous therapies tried and failed.
J0725	Injection, chorionic gonadotropin, per 1,000 USP units	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
J0739	Injection, cabotegravir, 1 mg	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
J0750	Emtrictabine 200 mg and tenofovir disoproxil fumarate 300 mg, oral, FDA approved prescription, only for use as HIV pre-exposure prophylaxis	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.

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J0751	Emtricitabine 200 mg and tenofovir alafenamide 25 mg, oral, FDA approved for prescription, only for use as HIV pre-exposure prophylaxis	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
J0775	Injection, collagenase, clostridium histolyticum, 0.01 mg	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
J0791	Injection, crizanlizumab-tmca, 5 mg	Prior Authorization Required	Medical necessity including site of service	This drug requires review for site of service administration in addition to review for prior authorization/medical necessity. Submit history and physical and recent lab work.
J0799	FDA approved prescription drug, only for use as HIV pre-exposure prophylaxis (not for use as treatment of HIV)), not otherwise classified	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
J0801	Injection, corticotropin (acthar gel), up to 40 units	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
J0802	Injection, corticotropin (ani), up to 40 units	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
J0850	Injection, cytomegalovirus immune globulin intravenous (human), per vial	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
J0879	Injection, difelikefalin, 0.1 microgram, (for ESRD on dialysis)	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
J0881	Injection, darbepoetin alfa, 1 mcg (non-ESRD use)	Prior Authorization Required	Medical Necessity	Submit chart notes from the ordering physician including history and physical with Hgb level and transferrin saturation or ferritin level within 1 month of initiating ESA and monthly
J0882	Injection, darbepoetin alfa, 1 mcg (for ESRD on dialysis)	Prior Authorization Required	Medical Necessity	Submit chart notes from the ordering physician including history and physical with Hgb level and transferrin saturation or ferritin level within 1 month of initiating ESA and monthly.

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J0885	Injection, epoetin alfa, (for non-ESRD use), 1000 units	Prior Authorization Required	Medical Necessity	Submit chart notes from the ordering physician including history and physical with Hgb level and transferrin saturation or ferritin level within 1 month of initiating ESA and monthly.
J0887	Injection, epoetin beta, 1 microgram, (for ESRD on dialysis)	Prior Authorization Required	Medical Necessity	Submit chart notes from the ordering physician including history and physical with Hgb level and transferrin saturation or ferritin level within 1 month of initiating ESA and monthly.
J0888	Injection, epoetin beta, 1 microgram, (for non-ESRD use)	Prior Authorization Required	Medical Necessity	Submit chart notes from the ordering physician including history and physical with Hgb level and transferrin saturation or ferritin level within 1 month of initiating ESA and monthly.
J0889	Daprodustat, oral, 1 mg, (for ESRD on dialysis)	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
J0894	Injection, decitabine, 1 mg	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
J0896	Injection, luspatercept-aamt, 0.25 mg	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
J0897	Injection, denosumab, 1 mg	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
J0901	Vadadustat, oral, 1 mg (for esrd on dialysis)	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
J1072	Injection, testosterone cypionate (Azmiro), 1 mg	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
J1202	Miglustat, oral, 65 mg	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
J1203	Injection, cipaglucosidase alfa-atga, 5 mg	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
J1290	Injection, ecallantide, 1 mg	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.

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J1299	Injection, eculizumab, 2 mg	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
J1300	Injection, eculizumab, 10 mg	Prior Authorization Required	Medical necessity including site of service	This drug requires review for site of service administration in addition to review for prior authorization/medical necessity. Submit history and physical and recent lab work.
J1301	Injection, edaravone, 1 mg	Prior Authorization Required	Medical Necessity	History and Physical, including prior treatments and proposed treatment plan
J1302	Injection, sutimlimab-jome, 10 mg	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
J1303	Injection, ravulizumab-cwvz, 10 mg	Prior Authorization Required	Medical necessity including site of service	This drug requires review for site of service administration in addition to review for prior authorization/medical necessity. Submit history and physical and recent lab work.
J1304	Injection, Tofersen, 1 mg	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
J1305	Injection, evinacumab-dgnb, 5 mg	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
J1306	Injection, inclisiran, 1 mg	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
J1307	Injection, crovalimab-akkz, 10 mg	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
J1322	Injection, elosulfase alfa, 1 mg	Prior Authorization Required	Medical necessity including site of service	This drug requires review for site of service administration in addition to review for prior authorization/medical necessity. Submit history and physical and recent lab work.
J1323	Injection, elranatamab-bcmm, 1 mg	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.

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J1325	Injection, epoprostenol, 0.5 mg	Prior Authorization Required	Medical Necessity	History and physical demonstrating reason for requested medication, lab work if applicable, dosage and duration of treatment, office notes related to condition, medical necessity and documentation of previous therapies/treatments tried
J1411	Injection, etranacogene dezaparvovec-drlb, per therapeutic dose	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
J1412	Injection, valoctocogene roxaparvovec-rvox, per ml, containing nominal 2x10^13 vector genomes	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
J1413	Injection, delandistrogene moxeparvovec-rokl, per therapeutic dose	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
J1426	Injection, casimersen, 10 mg	Prior Authorization Required	Medical necessity including site of service	Submit recent history and physical, plan of care, and documentation of medical necessity including for site of service.
J1427	Injection, Viltolarsen, 10mg	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity and procedure report.
J1428	Injection, eteplirsen, 10 mg	Prior Authorization Required	Medical necessity including site of service	This drug requires review for site of service administration in addition to review for prior authorization/medical necessity. Submit history and physical and recent lab work.
J1429	Injection, golodirsen, 10 mg	Prior Authorization Required	Medical necessity including site of service	This drug requires review for site of service administration in addition to review for prior authorization/medical necessity. Submit history and physical and recent lab work.
J1437	Injection, ferric derisomaltose, 10 mg	Prior Authorization Required	Investigative	Submit history and physical, documentation of medical necessity.

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J1438	Injection Etanercept (Enbrel) 25 MG	Prior Authorization Required	Medical Necessity	Submit review via Fax to Pharmacy Services @ 888-260-9836 or via ePA. Submit office notes related to condition, medical necessity and documentation of previous therapies/treatments tried, dosage and duration of treatment.
J1439	Injection, ferric carboxymaltose, 1 mg	Prior Authorization Required	Investigative	Submit history and physical, documentation of medical necessity.
J1440	Fecal microbiota, live - jslm, 1 ml	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
J1442	Injection, filgrastim (G-CSF), excludes biosimilars, 1 microgram	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity including prior treatments.
J1448	Injection, trilaciclib, 1 mg	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
J1449	Injection, eflapegrastim-xnst, 0.1 mg	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity including prior treatments.
J1458	Injection, galsulfase, 1 mg	Prior Authorization Required	Medical necessity including site of service	This drug requires review for site of service administration in addition to review for prior authorization/medical necessity. Submit history and physical and recent lab work.
J1459	Injection, immune globulin (Privigen), intravenous, nonlyophilized (e.g., liquid), 500 mg	Prior Authorization Required	Medical necessity including site of service	This drug requires review for site of service administration in addition to review for prior authorization/medical necessity. Submit history and physical and recent lab work.
J1551	Injection, immune globulin (Cutaquig), 100 mg	Prior Authorization Required	Medical necessity including site of service	Submit recent history and physical, plan of care, and documentation of medical necessity including for site of service.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
J1552	Injection, immune globulin (alyglo), 500 mg	Prior Authorization Required	Medical necessity including site of service	This drug requires review for site of service administration in addition to review for prior authorization/medical necessity. Submit history and physical and recent lab work.
J1554	Injection, immune globulin (asceniv), 500 mg	Prior Authorization Required	Medical necessity including site of service	This drug requires review for site of service administration in addition to review for prior authorization/medical necessity. Submit history and physical and recent lab work.
J1555	Injection, immune globulin (Cuvitru), 100 mg	Prior Authorization Required	Medical necessity including site of service	This drug requires review for site of service administration in addition to review for prior authorization/medical necessity. Submit history and physical and recent lab work.
J1556	Injection, immune globulin (bivigam), 500 mg	Prior Authorization Required	Medical necessity including site of service	This drug requires review for site of service administration in addition to review for prior authorization/medical necessity. Submit history and physical and recent lab work.
J1557	Injection, immune globulin, (Gammaplex), intravenous, nonlyophilized (e.g., liquid), 500 mg	Prior Authorization Required	Medical necessity including site of service	This drug requires review for site of service administration in addition to review for prior authorization/medical necessity. Submit history and physical and recent lab work.
J1558	Injection, immune globulin (xembify), 100 mg	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
J1559	Injection, immune globulin (Hizentra), 100 mg	Prior Authorization Required	Medical necessity including site of service	This drug requires review for site of service administration in addition to review for prior authorization/medical necessity. Submit history and physical and recent lab work.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
J1561	Injection, immune globulin, (Gamunex), intravenous, nonlyophilized (e.g., liquid), 500 mg	Prior Authorization Required	Medical necessity including site of service	This drug requires review for site of service administration in addition to review for prior authorization/medical necessity. Submit history and physical and recent lab work.
J1566	Injection, immune globulin, intravenous, lyophilized (e.g., powder), not otherwise specified, 500 mg	Prior Authorization Required	Medical necessity including site of service	This drug requires review for site of service administration in addition to review for prior authorization/medical necessity. Submit history and physical and recent lab work.
J1568	Injection, immune globulin, (Octagam), intravenous, nonlyophilized (e.g., liquid), 500 mg	Prior Authorization Required	Medical necessity including site of service	This drug requires review for site of service administration in addition to review for prior authorization/medical necessity. Submit history and physical and recent lab work.
J1569	Injection, immune globulin, (Gammagard liquid), intravenous, nonlyophilized, (e.g., liquid), 500 mg	Prior Authorization Required	Medical necessity including site of service	This drug requires review for site of service administration in addition to review for prior authorization/medical necessity. Submit history and physical and recent lab work.
J1572	Injection, immune globulin, (Flebogamma/Flebogamma Dif), intravenous, nonlyophilized (e.g., liquid), 500 mg	Prior Authorization Required	Medical necessity including site of service	This drug requires review for site of service administration in addition to review for prior authorization/medical necessity. Submit history and physical and recent lab work.
J1575	Injection, immune globulin/Hyaluronidase, (HYQVIA), 100 MG immune globulin	Prior Authorization Required	Medical necessity including site of service	This drug requires review for site of service administration in addition to review for prior authorization/medical necessity. Submit history and physical and recent lab work.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
J1576	Injection, immune globulin (panzyga), intravenous, non-lyophilized (e.g., liquid), 500 mg	Prior Authorization Required	Medical necessity including site of service	This drug requires review for site of service administration in addition to review for prior authorization/medical necessity. Submit history and physical and recent lab work.
J1595	Injection, glatiramer acetate, 20 mg	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, treatment plan
J1599	Injection, immune globulin, intravenous, nonlyophilized (e.g., liquid), not otherwise specified, 500 mg	Prior Authorization Required	Medical necessity including site of service	Submit recent history and physical, plan of care, and documentation of medical necessity including for site of service.
J1602	Injection, golimumab, 1 mg, for intravenous use	Prior Authorization Required	Medical necessity including site of service	This drug requires review for site of service administration in addition to review for prior authorization/medical necessity. Submit history and physical and recent lab work.
J1628	Injection, guselkumab, 1 mg	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
J1632	Injection, brexanolone, 1 mg	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
J1743	Injection, idursulfase, 1 mg	Prior Authorization Required	Medical necessity including site of service	This drug requires review for site of service administration in addition to review for prior authorization/medical necessity. Submit history and physical and recent lab work.
J1744	Injection, icatibant, 1 mg	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
J1745	Injection, infliximab, excludes biosimilar, 10 mg	Prior Authorization Required	Medical necessity including site of service	This drug requires review for site of service administration in addition to review for prior authorization/medical necessity. Submit history and physical and recent lab work.
J1746	Injection, ibalizumab-uiyk, 10 mg	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
J1747	Injection, Spesolimab-sbzo, 1 mg	Prior Authorization Required	Medical necessity including site of service	Submit recent history and physical, plan of care, and documentation of medical necessity including for site of service.
J1786	Injection, imiglucerase, 10 units	Prior Authorization Required	Medical necessity including site of service	This drug requires review for site of service administration in addition to review for prior authorization/medical necessity. Submit history and physical and recent lab work.
J1813	Insulin (lyumjev) for administration through dme (i.e., insulin pump) per 50 units	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
J1814	Insulin (lyumjev), per 5 units	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
J1823	Injection, inebilizumab-cdon, 1 mg	Prior Authorization Required	Medical necessity including site of service	This drug requires review for site of service administration in addition to review for prior authorization/medical necessity. Submit history and physical and recent lab work.
J1826	Injection, interferon beta-1a, 30 mcg	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, treatment plan
J1830	Injection interferon beta-1b, 0.25 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 Required	Medical Necessity	History and physical, documentation of medical necessity, treatment plan
J1930	Injection, lanreotide, 1 mg	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
J1931	Injection, laronidase, 0.1 mg	Prior Authorization Required	Medical necessity including site of service	This drug requires review for site of service administration in addition to review for prior authorization/medical necessity. Submit history and physical and recent lab work.

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J1950	Injection, leuprolide acetate (for depot suspension), per 3.75 mg	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
J1951	Injection, leuprolide acetate for depot suspension (fensolvi), 0.25 mg	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity and procedure report.
J1952	Leuprolide injectable, camcevi, 1 mg	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity and procedure report.
J1954	Injection, leuprolide acetate for depot suspension (Cipla), 7.5 mg	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
J1961	Injection, lenacapavir, 1 mg	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
J2170	Injection, mecasermin, 1 mg	Prior Authorization Required	Medical Necessity	History and Physical, including prior treatments and proposed treatment plan
J2182	Injection, Mepolizumab, 1 MG	Prior Authorization Required	Medical Necessity	Submit History and Physical, documentation of medical necessity including prior treatments
J2267	Injection, mirikizumab-mrkz, 1 mg	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
J2277	Injection, motixafortide, 0.25 mg	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
J2323	Injection, natalizumab, 1 mg	Prior Authorization Required	Medical necessity including site of service	Submit recent history and physical, plan of care, and documentation of medical necessity including for site of service.
J2326	Injection, nusinersen, 0.1 mg	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
J2327	Injection, risankizumab-rzaa, intravenous, 1 mg	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
J2329	Injection, ublituximab-xiiy, 1mg	Prior Authorization Required	Medical necessity including site of service	This drug requires review for site of service administration in addition to review for prior authorization/medical necessity. Submit history and physical and recent lab work.
J2350	Injection, ocrelizumab, 1 mg	Prior Authorization Required	Medical necessity including site of service	This drug requires review for site of service administration in addition to review for prior authorization/medical necessity. Submit history and physical and recent lab work.
J2351	Injection, ocrelizumab, 1 mg and hyaluronidase-ocsq	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
J2353	Injection, octreotide, depot form for intramuscular injection, 1 mg	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
J2354	Injection, octreotide, nondepot form for subcutaneous or intravenous injection, 25 mcg	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
J2356	Injection, tezepelumab-ekko, 1 mg	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
J2357	Injection, omalizumab, 5 mg	Prior Authorization Required	Medical Necessity	History and physical demonstrating reason for requested medication, lab work if applicable, dosage and duration of treatment, office notes related to condition, medical necessity and documentation of previous therapies/treatments tried
J2502	Injection, Pasireotide Long Acting, 1 MG	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity including prior treatments. No review needed for members under age 18.
J2503	Injection, pegaptanib sodium, 0.3 mg	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.

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J2506	Injection, pegfilgrastim, excludes biosimilar, 0.5 mg	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity including prior treatments.
J2507	Injection, pegloticase, 1 mg	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity including prior treatments. No review needed for members under age 18.
J2508	Injection, pegunigalsidase alfa-iwxj, 1 mg	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
J2777	Injection, faricimab-svoa, 0.1 mg	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
J2778	Injection, ranibizumab, 0.1 mg	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
J2779	Injection, ranibizumab, via intravitreal implant (Susvimo), 0.1 mg	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
J2781	Injection, Pegcetacoplan, intravitreal, 1 mg	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
J2782	Injection, avacincaptad pegol, 0.1 mg	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
J2783	Injection, rasburicase, 0.5 mg	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
J2786	Injection, reslizumab, 1 mg	Prior Authorization Required	Medical necessity including site of service	This drug requires review for site of service administration in addition to review for prior authorization/medical necessity. Submit history and physical and recent lab work.
J2793	Injection, rilonacept, 1 mg	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, treatment plan
J2802	Injection, romiplostim, 1 microgram	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
J2820	Injection, sargramostim (GM-CSF), 50 mcg	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity, treatment plan.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
J2840	Injection, sebelipase alfa, 1 mg	Prior Authorization Required	Medical necessity including site of service	This drug requires review for site of service administration in addition to review for prior authorization/medical necessity. Submit history and physical and recent lab work.
J2860	Injection, siltuximab, 10 mg	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
J2941	Injection, somatropin, 1 mg	Prior Authorization Required	Medical Necessity	If had previous treatment, indicate which preferred product was used; and use following criteria. For Children: History and physical, office notes related to condition being treated; notes demonstrating height velocity over previous year, and bone age or epiphyses confirmed open. For Adults: History and physical, office notes related to condition being treated; notes demonstrating clinical benefit (e.g., improvement in bone density, or cholesterol studies)
J2998	Injection, plasminogen, human-tvmh, 1 mg	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
J3031	Injection, fremanezumab-vfrm, 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 Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
J3032	Injection, eptinezumab-jjmr, 1 mg	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
J3055	Injection, talquetamab-tgvs, 0.25 mg	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
J3060	Injection, taliglucerase alfa, 10 units	Prior Authorization Required	Medical necessity including site of service	This drug requires review for site of service administration in addition to review for prior authorization/medical necessity. Submit history and physical and recent lab work.
J3110	Injection, teriparatide, 10 mcg	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
J3111	Injection, romosozumab-aqqg, 1 mg	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
J3145	Injection, testosterone undecanoate, 1 mg	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
J3241	Injection, teprotumumab-trbw, 10 mg	Prior Authorization Required	Medical Necessity	History and physical demonstrating reason for requested medication, lab work if applicable, dosage and duration of treatment, office notes related to condition, medical necessity and documentation of previous therapies/treatments tried
J3245	Injection, tildrakizumab, 1 mg	Prior Authorization Required	Medical Necessity	History and Physical, including prior treatments and proposed treatment plan
J3247	Injection, secukinumab, intravenous, 1 mg	Prior Authorization Required	Medical necessity including site of service	Submit recent history and physical, plan of care, and documentation of medical necessity including for site of service.
J3262	Injection, tocilizumab, 1 mg (Actemra)	Prior Authorization Required	Medical necessity including site of service	The IV form of this drug requires review for site of service administration in addition to prior authorization/medical necessity review. Submit history and physical and recent lab work.
J3263	Injection, toripalimab-tpzi, 1 mg	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
J3285	Injection, treprostinil, 1 mg	Prior Authorization Required	Medical Necessity	History and physical demonstrating reason for requested medication, lab work if applicable, dosage and duration of treatment, office notes related to condition, medical necessity and documentation of previous therapies/treatments tried
J3299	Injection, triamcinolone acetonide (Xipere), 1 mg	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
J3304	Injection, triamcinolone acetonide, preservative-free, extended-release, microsphere formulation, 1 mg	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
J3315	Injection, triptorelin pamoate, 3.75 mg	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
J3316	Injection, triptorelin, extended-release, 3.75 mg	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity and procedure report.
J3355	Injection, urofollitropin, 75 IU	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
J3357	Injection, ustekinumab, 1 mg	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
J3358	Ustekinumab, for intravenous injection, 1 mg	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
J3380	Injection, Vedolizumab, intravenous 1 mg	Prior Authorization Required	Medical necessity including site of service	This drug requires review for site of service administration in addition to review for prior authorization/medical necessity. Submit history and physical and recent lab work.
J3385	Injection, velaglucerase alfa, 100 units	Prior Authorization Required	Medical necessity including site of service	This drug requires review for site of service administration in addition to review for prior authorization/medical necessity. Submit history and physical and recent lab work.

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J3392	Injection, exagamglogene autotemcel, per treatment	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
J3393	Injection, betibeglogene autotemcel, per treatment	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
J3394	Injection, lovotibeglogene autotemcel, per treatment	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
J3397	Injection, vestronidase alfa-vjbk, 1 mg	Prior Authorization Required	Medical necessity including site of service	This drug requires review for site of service administration in addition to review for prior authorization/medical necessity. Submit history and physical and recent lab work.
J3398	Injection, voretigene neparvovec-rzyl, 1 billion vector genomes	Prior Authorization Required	Medical Necessity	History and Physical, including prior treatments and proposed treatment plan
J3399	Injection, onasemnogene abeparvovec-xioi, per treatment, up to 5x10^15 vector genomes	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
J3401	Beremagene geperpavec-svdt for topical administration, containing nominal 5x10^9 pfu/ml vector genomes, per 0.1 ml	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
J3490	Unclassified drugs	Medical necessity review will be performed upon claims submission with supporting documentation.	Medical Necessity	Upon claims submission Medical necessity review will be performed. Submit documentation to describe the medication, Include chart notes with drug name, NDC number and quantity.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
J3590	Unclassified biologics	Medical necessity review will be performed upon claims submission with supporting documentation.	Medical Necessity	Upon claims submission Medical necessity review will be performed. Submit documentation to describe the medication, Include chart notes with drug name and NDC number. History and physical demonstrating reason for requested medication, lab work if applicable, dosage and duration of treatment, office notes related to condition, medical necessity and documentation of previous therapies/ treatments tried.
J7170	Injection, emicizumab-kxwh, 0.5 mg	Prior Authorization Required	Medical Necessity	History and Physical, including prior treatments and proposed treatment plan
J7171	Injection, adamts13, recombinant-krhn, 10 iu	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
J7311	Injection, Fluocinolone acetonide, intravitreal implant (Retisert), 0.01 mg	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
J7312	Injection, dexamethasone, intravitreal implant, 0.1 mg	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
J7313	Injection, fluocinolone acetonide, intravitreal implant (Iluvien), 0.01 mg	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
J7314	Injection, fluocinolone acetonide, intravitreal implant (Yutiq), 0.01 mg	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
J7318	Hyaluronan or derivative, durolane, for intra-articular injection, 1 mg	Generally Not Covered	Not Medically Necessary	Not medically necessary for knee injections. Medical records optional. See medical policy 2.01.534.
J7320	Hyaluronan or derivative, Genvisc 850, for intra-articular injection, 1 MG	Generally Not Covered	Not Medically Necessary	Not medically necessary for knee injections. Medical records optional. See medical policy 2.01.534.
J7321	Hyaluronan or derivative, Hyalgan, Supartz or Visco-3, for intra-articular injection, per dose	Generally Not Covered	Not Medically Necessary	Not medically necessary for knee injections. Medical records optional. See medical policy 2.01.534.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
J7322	Hyaluronan or derivative, Hymovis, for intra-articular injection, 1 MG	Generally Not Covered	Not Medically Necessary	Not medically necessary for knee injections. Medical records optional. See medical policy 2.01.534.
J7323	Hyaluronan or derivative, Euflexxa, for intra-articular injection, per dose	Generally Not Covered	Not Medically Necessary	Not medically necessary for knee injections. Medical records optional. See medical policy 2.01.534.
J7324	Hyaluronan or derivative, Orthovisc, for intra-articular injection, per dose	Generally Not Covered	Not Medically Necessary	Not medically necessary for knee injections. Medical records optional. See medical policy 2.01.534.
J7325	Hyaluronan or derivative, Synvisc or Synvisc-One, for intra-articular injection, 1 mg	Generally Not Covered	Not Medically Necessary	Not medically necessary for knee injections. Medical records optional. See medical policy 2.01.534.
J7326	Hyaluronan or derivative, Gel-One, for intra-articular injection, per dose	Generally Not Covered	Not Medically Necessary	Not medically necessary for knee injections. Medical records optional. See medical policy 2.01.534.
J7327	Hyaluronan or derivative, Monovisc, for intra-articular injection, per dose	Generally Not Covered	Not Medically Necessary	Not medically necessary for knee injections. Medical records optional. See medical policy 2.01.534.
J7328	Hyaluronan or derivative, Gel-Syn, for intra-articular injection, 0.1 MG	Generally Not Covered	Not Medically Necessary	Not medically necessary for knee injections. Medical records optional. See medical policy 2.01.534.
J7329	Hyaluronan or derivative, trivisc, for intra-articular injection, 1 mg	Generally Not Covered	Not Medically Necessary	Not medically necessary for knee injections. Medical records optional. See medical policy 2.01.534.
J7330	Autologous cultured chondrocytes, implant	Prior Authorization Required	Medical necessity including site of service	This drug requires review for site of service administration in addition to review for prior authorization/medical necessity. Submit history and physical and recent lab work.
J7331	Hyaluronan or derivative, SYNOJOYNT, for intra-articular injection, 1 mg	Generally Not Covered	Not Medically Necessary	Not medically necessary for knee injections. Medical records optional. See medical policy 2.01.534.

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J7332	Hyaluronan or derivative, Triluron, for intra-articular injection, 1 mg	Generally Not Covered	Not Medically Necessary	Not medically necessary for knee injections. Medical records optional. See medical policy 2.01.534.
J7336	Capsaicin 8% patch, per sq cm	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
J7351	Injection, bimatoprost, intracameral implant, 1 mcg	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
J7352	Afamelanotide implant, 1 mg	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
J7353	Anacaulase-BCDB, 8.8% gel, 1 gram	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
J7354	Cantharidin for topical administration, 0.7%, single unit dose applicator (3.2 mg)	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
J7355	Injection, travoprost, intracameral implant, 1 microgram	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
J7402	Mometasone furoate sinus implant, (Sinuva), 10 mcg	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
J7599	Immunosuppressive drug, not otherwise classified	Medical necessity review will be performed upon claims submission with supporting documentation.	Medical Necessity	Review required at claims submission; submit description of procedure with supporting documentation (including operative report if surgical) only for the date of service performed.
J7686	Treprostinil, inhalation solution, FDA-approved final product, noncompounded, administered through DME, unit dose form, 1.74 mg	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
J7999	Compounded drug, not otherwise classified	Medical necessity review will be performed upon claims submission with supporting documentation.	Medical Necessity	Upon claims submission Medical necessity review will be performed. Submit documentation to describe the medication, Include chart notes with drug name, NDC number and quantity.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
J8499	Prescription drug, oral, non-chemotherapeutic, NOS (Includes: Revlimid)	Medical necessity review will be performed upon claims submission with supporting documentation.	Medical Necessity	Upon claims submission Medical necessity review will be performed. Submit documentation to describe the medication, Include chart notes with drug name, NDC number and quantity.
J8597	Antiemetic drug, oral, not otherwise specified	Medical necessity review will be performed upon claims submission with supporting documentation.	Medical Necessity	Review required at claims submission; submit description of procedure with supporting documentation (including operative report if surgical) only for the date of service performed.
J8611	Methotrexate (jylamvo), oral, 2.5 mg	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
J8612	Methotrexate (xatmep), oral, 2.5 mg	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
J9019	Injection, asparaginase (Erwinaze), 1,000 IU	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
J9021	Injection, asparaginase, recombinant, (Rylaze), 0.1 mg	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
J9022	Injection, atezolizumab, 10 mg	Prior Authorization Required	Medical Necessity	Submit History and Physical, documentation of medical necessity, treatment plan
J9023	Injection, avelumab, 10 mg	Prior Authorization Required	Medical Necessity	Submit History and Physical, documentation of medical necessity, treatment plan
J9024	Injection, atezolizumab, 5 mg and hyaluronidase-tqjs	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
J9026	Injection, tarlatamab-dlle, 1 mg	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
J9028	Injection, nogapendekin alfa inbakicept-pmln, for intravesical use, 1 microgram	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
J9029	Intravesical instillation, nadofaragene firadenovec-vncg, per therapeutic dose	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
J9032	Injection, Belinostat, 10 MG	Prior Authorization Required	Medical Necessity	History and Physical, including prior treatments and proposed treatment plan
J9034	Injection, bendamustine HCl (Bendeka), 1 mg	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
J9035	Injection, bevacizumab, 10 mg	Prior Authorization Required	Medical Necessity	History and Physical including prior treatments and proposed treatment plan. Please do not send infusion records. No review needed for Eye related injections.
J9036	Injection, bendamustine HCl, (Belrapzo/bendamustine), 1 mg	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
J9038	Injection, axatilimab-csfr, 0.1 mg	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
J9039	Injection, blinatumomab, 1 mcg	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity, treatment plan.
J9041	Injection, bortezomib, 0.1 mg	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
J9042	Injection, brentuximab vedotin, 1 mg	Prior Authorization Required	Medical Necessity	History and Physical, including prior treatments and proposed treatment plan
J9043	Injection, cabazitaxel, 1 mg	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity and procedure report.
J9046	Injection, bortezomib (Dr. Reddy's), not therapeutically equivalent to J9041, 0.1 mg	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
J9047	Injection, carfilzomib, 1 mg	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
J9048	Injection, bortezomib (Fresenius Kabi), not therapeutically equivalent to J9041, 0.1 mg	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.

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J9049	Injection, bortezomib (Hospira), not therapeutically equivalent to J9041, 0.1 mg	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
J9051	Injection, Bortezomib (MAIA), not therapeutically equivalent to J9041, 0.1 mg	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
J9054	Injection, bortezomib (boruzu), 0.1 mg	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
J9055	Injection, cetuximab, 10 mg	Prior Authorization Required	Medical Necessity	History and Physical, including prior treatments and proposed treatment plan
J9056	Injection, bendamustine HCl (Vivimusta), 1 mg	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
J9057	Injection, copanlisib, 1 mg	Prior Authorization Required	Medical Necessity	Submit History and Physical, documentation of medical necessity, treatment plan
J9061	Injection, amivantamab-vmjw, 2 mg	Prior Authorization Required	Medical Necessity	History and Physical, including prior treatments and proposed treatment plan
J9063	Injection, mirvetuximab soravtansine-gynx, 1 mg	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
J9118	Injection, calaspargase pegol-mknl, 10 units	Prior Authorization Required	Medical Necessity	Submit History and Physical, documentation of medical necessity, treatment plan
J9119	Injection, cemiplimab-rwlc, 1 mg	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
J9144	Injection, daratumumab, 10 mg and hyaluronidase-fihj	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
J9145	Injection, daratumumab, 10 mg	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
J9153	Injection, liposomal, 1 mg daunorubicin and 2.27 mg cytarabine	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
J9155	Injection, degarelix, 1 mg	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity and procedure report.
J9161	Injection, denileukin diftitox-cxdl, 1 mcg	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
J9173	Injection, durvalumab, 10 mg	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
J9176	Injection, elotuzumab, 1 mg	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
J9177	Injection, enfortumab vedotin-ejfv, 0.25 mg	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
J9179	Injection, eribulin mesylate, 0.1 mg	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
J9202	Goserelin acetate implant, per 3.6 mg	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity and procedure report.
J9203	Injection, gemtuzumab ozogamicin, 0.1 mg	Prior Authorization Required	Medical Necessity	Submit History and Physical, documentation of medical necessity, treatment plan
J9204	Injection, mogamulizumab-kpkc, 1 mg	Prior Authorization Required	Medical Necessity	History and Physical, including prior treatments and proposed treatment plan
J9205	Injection, irinotecan liposome, 1 mg	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
J9210	Injection, emapalumab-lzsg, 1 mg	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
J9214	Injection, interferon, alfa-2b, recombinant, 1 million units	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity, treatment plan.
J9216	Injection, interferon, gamma 1-b, 3 million units	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
J9217	Leuprolide acetate (for depot suspension), 7.5 mg	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity and procedure report.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
J9218	Leuprolide acetate, per 1 mg	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity and procedure report.
J9223	Injection, lurbinectedin, 0.1 mg	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
J9225	Histrelin implant (Vantas), 50 mg	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity and procedure report.
J9226	Histrelin implant (Supprelin LA), 50 mg	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity and procedure report.
J9227	Injection, isatuximab-irfc, 10 mg	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
J9228	Injection, ipilimumab, 1 mg	Prior Authorization Required	Medical Necessity	History and Physical, including prior treatments and proposed treatment plan
J9229	Injection, inotuzumab ozogamicin, 0.1 mg	Prior Authorization Required	Medical Necessity	Submit History and Physical, documentation of medical necessity, treatment plan
J9248	Injection, melphalan (hepzato), 1 mg	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
J9258	Injection, paclitaxel protein-bound particles (Teva), not therapeutically equivalent to J9264, 1 mg	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
J9261	Injection, nelarabine, 50 mg	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
J9264	Injection, paclitaxel protein-bound particles, 1 mg	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
J9266	Injection, pegaspargase, per single dose vial	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
J9268	Injection, pentostatin, 10 mg	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
J9269	Injection, tagraxofusp-erzs, 10 mcg	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
J9271	Injection, pembrolizumab, 1 mg	Prior Authorization Required	Medical necessity including site of service	Submit recent history and physical, plan of care, and documentation of medical necessity including for site of service.
J9272	Injection, dostarlimab-gxly, 10 mg	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
J9273	Injection, tisotumab vedotin-tftv, 1 mg	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
J9274	Injection, tebentafusp-tebn, 1 mcg	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
J9281	Mitomycin pyelocalyceal instillation, 1 mg	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
J9285	Injection, olaratumab, 10 mg	Prior Authorization Required	Medical Necessity	Submit History and Physical, documentation of medical necessity, treatment plan
J9286	Injection, glofitamab-gxbm, 2.5 mg	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
J9292	Injection, pemetrexed (avyxa), not therapeutically equivalent to j9305, 10 mg	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
J9294	Injection, Pemetrexed (Hospira), 10 mg	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
J9296	Injection, Pemetrexed (Accord), 10 mg	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
J9297	Injection, Pemetrexed (Sandoz), 10 mg	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
J9298	Injection, nivolumab and relatlimab-rmbw, 3 mg/1 mg	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
J9299	Injection, Nivolumab, 1 MG	Prior Authorization Required	Medical necessity including site of service	Submit recent history and physical, plan of care, and documentation of medical necessity including for site of service.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
J9301	Injection, obinutuzumab, 10 mg	Prior Authorization Required	Medical Necessity	History and Physical, including prior treatments and proposed treatment plan
J9302	Injection, ofatumumab, 10 mg (Arzerra)	Prior Authorization Required	Medical Necessity	History and physical demonstrating reason for requested medication, dosage and duration of treatment, office notes related to condition
J9303	Injection, panitumumab, 10 mg	Prior Authorization Required	Medical Necessity	History and Physical, including prior treatments and proposed treatment plan
J9304	Injection, pemetrexed (Pemfexy), 10 mg	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity, treatment plan.
J9305	Injection, pemetrexed, 10 mg	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity, treatment plan.
J9306	Injection, pertuzumab, 1 mg	Prior Authorization Required	Medical Necessity	History and Physical, including prior treatments and proposed treatment plan
J9307	Injection, pralatrexate, 1 mg	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity, treatment plan.
J9308	Injection, ramucirumab, 5 mg	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity, treatment plan.
J9309	Injection, polatuzumab vedotin-piiq, 1 mg	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity, treatment plan.
J9311	Injection, rituximab 10 mg and hyaluronidase	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
J9312	Injection, rituximab, 10 mg	Prior Authorization Required	Medical necessity including site of service	This drug requires review for site of service administration in addition to review for prior authorization/medical necessity. Submit history and physical and recent lab work.
J9313	Injection, moxetumomab pasudotox-tdfk, 0.01 mg	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, treatment plan
J9314	Injection, pemetrexed (Teva) not therapeutically equivalent to J9305, 10 mg	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
J9316	Injection, pertuzumab, trastuzumab, and hyaluronidase-zzxf, per 10 mg	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
J9317	Injection, sacituzumab govitecan-hziy, 2.5 mg	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
J9318	Injection, romidepsin, nonlyophilized, 0.1 mg	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
J9319	Injection, romidepsin, lyophilized, 0.1 mg	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
J9321	Injection, epcoritamab-bysp, 0.16 mg	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
J9322	Injection, pemetrexed (BluePoint) not therapeutically equivalent to J9305, 10 mg	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
J9323	Injection, pemetrexed (hospira) not therapeutically equivalent to j9305, 10 mg	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
J9324	Injection, pemetrexed (pemrydi rtu), 10 mg	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
J9325	Injection, Talimogene Laherparepvec, per 1 Million Plaque Forming Units	Prior Authorization Required	Medical Necessity	History and Physical, including prior treatments and proposed treatment plan
J9328	Injection, temozolomide, 1 mg	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.

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J9329	Injection, tislelizumab-jsgr, 1mg	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
J9330	Injection, temsirolimus, 1 mg (Torisel)	Prior Authorization Required	Medical Necessity	Submit office notes related to condition, medical necessity and documentation of previous therapies/treatments tried,dosage and duration of treatment
J9331	Injection, sirolimus protein-bound particles, 1 mg	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
J9332	Injection, efgartigimod alfa-fcab, 2 mg	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
J9333	Injection, rozanolixizumab-noli, 1 mg	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
J9334	Injection, efgartigimod alfa, 2 mg and hyaluronidase-qvfc	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
J9345	Injection, Retifanlimab-DLWR, 1 mg	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
J9347	Injection, Tremelimumab-actl, 1 mg	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
J9348	Injection, naxitamab-gqgk, 1 mg	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity, treatment plan.
J9349	Injection, tafasitamab-cxix, 2 mg	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
J9350	Injection, mosunetuzumab-axgb, 1 mg	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
J9352	Injection, trabectedin, 0.1 mg	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
J9353	Injection, margetuximab-cmkb, 5 mg	Prior Authorization Required	Medical Necessity	History and Physical, including prior treatments and proposed treatment plan
J9354	Injection, ado-trastuzumab emtansine, 1 mg	Prior Authorization Required	Medical Necessity	History and Physical, including prior treatments and proposed treatment plan

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
J9355	Injection, trastuzumab, excludes biosimilar, 10 mg	Prior Authorization Required	Medical Necessity	History and physical demonstrating reason for requested medication, and lab work demonstrating HER-2/neu over expression. Please do not include infusion records.
J9356	Injection, bendamustine hydrochloride, (Belrapzo/bendamustine), 1 mg	Prior Authorization Required	Medical Necessity	History and physical demonstrating reason for requested medication, and lab work demonstrating HER-2/neu over expression. Please do not include infusion records.
J9358	Injection, fam-trastuzumab deruxtecan-nxki, 1 mg	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
J9359	Injection, loncastuximab tesirine-lpyl, 0.075 mg	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
J9361	Injection, efbemalenograstim alfa-vuxw, 0.5 mg	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity including prior treatments.
J9376	Injection, pozelimab-bbfg, 1 mg	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
J9380	Injection, teclistamab-cqyv, 0.5 mg	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
J9381	Injection, Teplizumab-mzwv, 5 mcg	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
J9395	Injection, fulvestrant, 25 mg	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
J9400	Injection, ziv-aflibercept, 1 mg	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, treatment plan
J9999	Not otherwise classified, antineoplastic drugs	Prior Authorization Required	Unlisted Code	Submit history and physical, documentation of medical necessity.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
K0004	High strength, lightweight wheelchair	Prior Authorization Required	Medical Necessity	Submit history and physical to include the following: diagnosis; abilities and limitations as they relate to the equipment (e.g., degree of independence/ dependence, frequency and nature of the activities the patient performs, duration of medical condition, past experience if any using similar equipment, evaluation of upper extremity strength.
K0005	Ultralight weight wheelchair	Prior Authorization Required	Medical Necessity	Submit history and physical to include the following: diagnosis; abilities and limitations as they relate to the equipment (e.g., degree of independence/ dependence, frequency and nature of the activities the patient performs, duration of medical condition, past experience if any using similar equipment, evaluation of upper extremity strength.
K0008	Custom manual wheelchair base	Prior Authorization Required	Specialized DME	History and Physical to Include the following: diagnosis; abilities and limitations as they relate to the equipment (e.g., degree of independence/ dependence, frequency and nature of the activities the patient performs, duration of medical condition, Past experience if any using similar equipment, Evaluation of upper extremity strength. Include invoice of cost for item.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
K0009	Other manual wheelchair/base	Prior Authorization Required	Medical Necessity	Submit history and physical to include the following: diagnosis; abilities and limitations as they relate to the equipment (e.g., degree of independence/ dependence, frequency and nature of the activities the patient performs, duration of medical condition, past experience if any using similar equipment, evaluation of upper extremity strength.
K0010	Standard – weight frame motorized/power wheelchair	Prior Authorization Required	Medical Necessity	Submit history and physical to include the following: diagnosis; abilities and limitations as they relate to the equipment (e.g., degree of independence/ dependence, frequency and nature of the activities the patient performs, duration of medical condition, past experience if any using similar equipment, evaluation of upper extremity strength.
K0011	Standard-weight frame motorized/power wheelchair with programmable control parameters for speed adjustment, tremor dampening, acceleration control and braking	Prior Authorization Required	Medical Necessity	Submit history and physical to include the following: diagnosis; abilities and limitations as they relate to the equipment (e.g., degree of independence/ dependence, frequency and nature of the activities the patient performs, duration of medical condition, past experience if any using similar equipment, evaluation of upper extremity strength.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
K0012	Lightweight portable motorized/power wheelchair	Prior Authorization Required	Medical Necessity	Submit history and physical to include the following: diagnosis; abilities and limitations as they relate to the equipment (e.g., degree of independence/ dependence, frequency and nature of the activities the patient performs, duration of medical condition, past experience if any using similar equipment, evaluation of upper extremity strength.
K0013	Custom motorized/power wheelchair base	Prior Authorization Required	Specialized DME	History and Physical, Include the following: diagnosis; abilities and limitations as they relate to the equipment (e.g., degree of independence/ dependence, frequency and nature of the activities the patient performs, duration of medical condition). Past experience if any using similar equipment.
K0014	Other motorized/power wheelchair base	Prior Authorization Required	Medical Necessity	History and Physical to Include the following: diagnosis; abilities and limitations as they relate to the equipment (e.g., degree of independence/ dependence, frequency and nature of the activities the patient performs, duration of medical condition, Past experience if any using similar equipment, Evaluation of upper extremity strength, Documented inability to propel a manual chair
K0108	Wheelchair component or accessory, not otherwise specified	Prior Authorization Required	Medical Necessity	Letter of medical Necessity supporting need for the wheelchair accessory

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K0455	Infusion pump used for uninterrupted parenteral administration of medication, (e.g., epoprostenol or treprostinol)	Pre-Service Review Required	Medical Necessity	History and Physical indicating why treatment is being done
K0606	Automatic external defibrillator, with integrated electrocardiogram analysis, garment type	Prior Authorization Required	Medical Necessity	Recent History and Physical, plan of care, and documentation of medical necessity
K0607	Replacement battery for automated external defibrillator, each	Pre-Service Review Required	Medical Necessity	Recent History and Physical, plan of care, and documentation of medical necessity
K0608	Replacement garment for use with automated external defibrillator, each	Pre-Service Review Required	Medical Necessity	Recent History and Physical, plan of care, and documentation of medical necessity
K0609	Replacement electrodes for use with automated external defibrillator, each	Pre-Service Review Required	Medical Necessity	Recent History and Physical, plan of care, and documentation of medical necessity
K0669	Wheelchair accessory, wheelchair seat or back cushion, does not meet specific code criteria or no written coding verification from SADMERC	Prior Authorization Required	Medical Necessity	Letter of medical Necessity supporting need for the wheelchair accessory
K0800	Power operated vehicle, group 1 standard, patient weight capacity up to and including 300 pounds	Prior Authorization Required	Medical Necessity	Submit history and physical to include the following: diagnosis; abilities and limitations as they relate to the equipment (e.g., degree of independence/ dependence, frequency and nature of the activities the patient performs, duration of medical condition, past experience if any using similar equipment, evaluation of upper extremity strength.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
K0801	Power operated vehicle, group 1 heavy-duty, patient weight capacity 301 to 450 pounds	Prior Authorization Required	Medical Necessity	Submit history and physical to include the following: diagnosis; abilities and limitations as they relate to the equipment (e.g., degree of independence/ dependence, frequency and nature of the activities the patient performs, duration of medical condition, past experience if any using similar equipment, evaluation of upper extremity strength.
K0802	Power operated vehicle, group 1 very heavy-duty, patient weight capacity 451 to 600 pounds	Prior Authorization Required	Medical Necessity	Submit history and physical to include the following: diagnosis; abilities and limitations as they relate to the equipment (e.g., degree of independence/ dependence, frequency and nature of the activities the patient performs, duration of medical condition, past experience if any using similar equipment, evaluation of upper extremity strength.
K0806	Power operated vehicle, group 2 standard, patient weight capacity up to and including 300 pounds	Prior Authorization Required	Medical Necessity	Submit history and physical to include the following: diagnosis; abilities and limitations as they relate to the equipment (e.g., degree of independence/ dependence, frequency and nature of the activities the patient performs, duration of medical condition, past experience if any using similar equipment, evaluation of upper extremity strength.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
K0807	Power operated vehicle, group 2 heavy-duty, patient weight capacity 301 to 450 pounds	Prior Authorization Required	Medical Necessity	Submit history and physical to include the following: diagnosis; abilities and limitations as they relate to the equipment (e.g., degree of independence/ dependence, frequency and nature of the activities the patient performs, duration of medical condition, past experience if any using similar equipment, evaluation of upper extremity strength.
K0808	Power operated vehicle, group 2 very heavy-duty, patient weight capacity 451 to 600 pounds	Prior Authorization Required	Medical Necessity	Submit history and physical to include the following: diagnosis; abilities and limitations as they relate to the equipment (e.g., degree of independence/ dependence, frequency and nature of the activities the patient performs, duration of medical condition, past experience if any using similar equipment, evaluation of upper extremity strength.
K0812	Power operated vehicle, not otherwise classified	Prior Authorization Required	Medical Necessity	Submit history and physical to include the following: diagnosis; abilities and limitations as they relate to the equipment (e.g., degree of independence/ dependence, frequency and nature of the activities the patient performs, duration of medical condition, past experience if any using similar equipment, evaluation of upper extremity strength.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
K0813	Power wheelchair, group 1 standard, portable, sling/solid seat and back, patient weight capacity up to and including 300 pounds	Prior Authorization Required	Medical Necessity	Submit history and physical to include the following: diagnosis; abilities and limitations as they relate to the equipment (e.g., degree of independence/ dependence, frequency and nature of the activities the patient performs, duration of medical condition, past experience if any using similar equipment, evaluation of upper extremity strength.
K0814	Power wheelchair, group 1 standard, portable, captain's chair, patient weight capacity up to and including 300 pounds	Prior Authorization Required	Medical Necessity	Submit history and physical to include the following: diagnosis; abilities and limitations as they relate to the equipment (e.g., degree of independence/ dependence, frequency and nature of the activities the patient performs, duration of medical condition, past experience if any using similar equipment, evaluation of upper extremity strength.
K0815	Power wheelchair, group 1 standard, sling/solid seat and back, patient weight capacity up to and including 300 pounds	Prior Authorization Required	Medical Necessity	Submit history and physical to include the following: diagnosis; abilities and limitations as they relate to the equipment (e.g., degree of independence/ dependence, frequency and nature of the activities the patient performs, duration of medical condition, past experience if any using similar equipment, evaluation of upper extremity strength.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
K0816	Power wheelchair, group 1 standard, captain's chair, patient weight capacity up to and including 300 pounds	Prior Authorization Required	Medical Necessity	Submit history and physical to include the following: diagnosis; abilities and limitations as they relate to the equipment (e.g., degree of independence/ dependence, frequency and nature of the activities the patient performs, duration of medical condition, past experience if any using similar equipment, evaluation of upper extremity strength.
K0820	Power wheelchair, group 2 standard, portable, sling/solid seat/back, patient weight capacity up to and including 300 pounds	Prior Authorization Required	Medical Necessity	Submit history and physical to include the following: diagnosis; abilities and limitations as they relate to the equipment (e.g., degree of independence/ dependence, frequency and nature of the activities the patient performs, duration of medical condition, past experience if any using similar equipment, evaluation of upper extremity strength.
K0821	Power wheelchair, group 2 standard, portable, captain's chair, patient weight capacity up to and including 300 pounds	Prior Authorization Required	Medical Necessity	Submit history and physical to include the following: diagnosis; abilities and limitations as they relate to the equipment (e.g., degree of independence/ dependence, frequency and nature of the activities the patient performs, duration of medical condition, past experience if any using similar equipment, evaluation of upper extremity strength.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
K0822	Power wheelchair, group 2 standard, sling/solid seat/back, patient weight capacity up to and including 300 pounds	Prior Authorization Required	Medical Necessity	Submit history and physical to include the following: diagnosis; abilities and limitations as they relate to the equipment (e.g., degree of independence/ dependence, frequency and nature of the activities the patient performs, duration of medical condition, past experience if any using similar equipment, evaluation of upper extremity strength.
K0823	Power wheelchair, group 2 standard, captain's chair, patient weight capacity up to and including 300 pounds	Prior Authorization Required	Medical Necessity	Submit history and physical to include the following: diagnosis; abilities and limitations as they relate to the equipment (e.g., degree of independence/ dependence, frequency and nature of the activities the patient performs, duration of medical condition, past experience if any using similar equipment, evaluation of upper extremity strength.
K0824	Power wheelchair, group 2 heavy-duty, sling/solid seat/back, patient weight capacity 301 to 450 pounds	Prior Authorization Required	Medical Necessity	Submit history and physical to include the following: diagnosis; abilities and limitations as they relate to the equipment (e.g., degree of independence/ dependence, frequency and nature of the activities the patient performs, duration of medical condition, past experience if any using similar equipment, evaluation of upper extremity strength.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
K0825	Power wheelchair, group 2 heavy-duty, captain's chair, patient weight capacity 301 to 450 pounds	Prior Authorization Required	Medical Necessity	Submit history and physical to include the following: diagnosis; abilities and limitations as they relate to the equipment (e.g., degree of independence/ dependence, frequency and nature of the activities the patient performs, duration of medical condition, past experience if any using similar equipment, evaluation of upper extremity strength.
K0826	Power wheelchair, group 2 very heavy duty, sling/solid seat/back, patient weight capacity 451 to 600 pounds	Prior Authorization Required	Medical Necessity	Submit history and physical to include the following: diagnosis; abilities and limitations as they relate to the equipment (e.g., degree of independence/ dependence, frequency and nature of the activities the patient performs, duration of medical condition, past experience if any using similar equipment, evaluation of upper extremity strength.
K0827	Power wheelchair, group 2 very heavy-duty, captain's chair, patient weight capacity 451 to 600 pounds	Prior Authorization Required	Medical Necessity	Submit history and physical to include the following: diagnosis; abilities and limitations as they relate to the equipment (e.g., degree of independence/ dependence, frequency and nature of the activities the patient performs, duration of medical condition, past experience if any using similar equipment, evaluation of upper extremity strength.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
K0828	Power wheelchair, group 2 extra heavy-duty, sling/solid seat/back, patient weight capacity 601 pounds or more	Prior Authorization Required	Medical Necessity	Submit history and physical to include the following: diagnosis; abilities and limitations as they relate to the equipment (e.g., degree of independence/ dependence, frequency and nature of the activities the patient performs, duration of medical condition, past experience if any using similar equipment, evaluation of upper extremity strength.
K0829	Power wheelchair, group 2 extra heavy-duty, captain's chair, patient weight 601 pounds or more	Prior Authorization Required	Medical Necessity	Submit history and physical to include the following: diagnosis; abilities and limitations as they relate to the equipment (e.g., degree of independence/ dependence, frequency and nature of the activities the patient performs, duration of medical condition, past experience if any using similar equipment, evaluation of upper extremity strength.
K0835	Power wheelchair, group 2 standard, single power option, sling/solid seat/back, patient weight capacity up to and including 300 pounds	Prior Authorization Required	Medical Necessity	Submit history and physical to include the following: diagnosis; abilities and limitations as they relate to the equipment (e.g., degree of independence/ dependence, frequency and nature of the activities the patient performs, duration of medical condition, past experience if any using similar equipment, evaluation of upper extremity strength.

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K0836	Power wheelchair, group 2 standard, single power option, captain's chair, patient weight capacity up to and including 300 pounds	Prior Authorization Required	Medical Necessity	Submit history and physical to include the following: diagnosis; abilities and limitations as they relate to the equipment (e.g., degree of independence/ dependence, frequency and nature of the activities the patient performs, duration of medical condition, past experience if any using similar equipment, evaluation of upper extremity strength.
K0837	Power wheelchair, group 2 heavy-duty, single power option, sling/solid seat/back, patient weight capacity 301 to 450 pounds	Prior Authorization Required	Medical Necessity	Submit history and physical to include the following: diagnosis; abilities and limitations as they relate to the equipment (e.g., degree of independence/ dependence, frequency and nature of the activities the patient performs, duration of medical condition, past experience if any using similar equipment, evaluation of upper extremity strength.
K0838	Power wheelchair, group 2 heavy-duty, single power option, captain's chair, patient weight capacity 301 to 450 pounds	Prior Authorization Required	Medical Necessity	Submit history and physical to include the following: diagnosis; abilities and limitations as they relate to the equipment (e.g., degree of independence/ dependence, frequency and nature of the activities the patient performs, duration of medical condition, past experience if any using similar equipment, evaluation of upper extremity strength.

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K0839	Power wheelchair, group 2 very heavy-duty, single power option sling/solid seat/back, patient weight capacity 451 to 600 pounds	Prior Authorization Required	Medical Necessity	Submit history and physical to include the following: diagnosis; abilities and limitations as they relate to the equipment (e.g., degree of independence/ dependence, frequency and nature of the activities the patient performs, duration of medical condition, past experience if any using similar equipment, evaluation of upper extremity strength.
K0840	Power wheelchair, group 2 extra heavy-duty, single power option, sling/solid seat/back, patient weight capacity 601 pounds or more	Prior Authorization Required	Medical Necessity	Submit history and physical to include the following: diagnosis; abilities and limitations as they relate to the equipment (e.g., degree of independence/ dependence, frequency and nature of the activities the patient performs, duration of medical condition, past experience if any using similar equipment, evaluation of upper extremity strength.
K0841	Power wheelchair, group 2 standard, multiple power option, sling/solid seat/back, patient weight capacity up to and including 300 pounds	Prior Authorization Required	Medical Necessity	Submit history and physical to include the following: diagnosis; abilities and limitations as they relate to the equipment (e.g., degree of independence/ dependence, frequency and nature of the activities the patient performs, duration of medical condition, past experience if any using similar equipment, evaluation of upper extremity strength.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
K0842	Power wheelchair, group 2 standard, multiple power option, captain's chair, patient weight capacity up to and including 300 pounds	Prior Authorization Required	Medical Necessity	Submit history and physical to include the following: diagnosis; abilities and limitations as they relate to the equipment (e.g., degree of independence/ dependence, frequency and nature of the activities the patient performs, duration of medical condition, past experience if any using similar equipment, evaluation of upper extremity strength.
K0843	Power wheelchair, group 2 heavy-duty, multiple power option, sling/solid seat/back, patient weight capacity 301 to 450 pounds	Prior Authorization Required	Medical Necessity	Submit history and physical to include the following: diagnosis; abilities and limitations as they relate to the equipment (e.g., degree of independence/ dependence, frequency and nature of the activities the patient performs, duration of medical condition, past experience if any using similar equipment, evaluation of upper extremity strength.
K0848	Power wheelchair, group 3 standard, sling/solid seat/back, patient weight capacity up to and including 300 pounds	Prior Authorization Required	Medical Necessity	Submit history and physical to include the following: diagnosis; abilities and limitations as they relate to the equipment (e.g., degree of independence/ dependence, frequency and nature of the activities the patient performs, duration of medical condition, past experience if any using similar equipment, evaluation of upper extremity strength.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
K0849	Power wheelchair, group 3 standard, captain's chair, patient weight capacity up to and including 300 pounds	Prior Authorization Required	Medical Necessity	Submit history and physical to include the following: diagnosis; abilities and limitations as they relate to the equipment (e.g., degree of independence/ dependence, frequency and nature of the activities the patient performs, duration of medical condition, past experience if any using similar equipment, evaluation of upper extremity strength.
K0850	Power wheelchair, group 3 heavy-duty, sling/solid seat/back, patient weight capacity 301 to 450 pounds	Prior Authorization Required	Medical Necessity	Submit history and physical to include the following: diagnosis; abilities and limitations as they relate to the equipment (e.g., degree of independence/ dependence, frequency and nature of the activities the patient performs, duration of medical condition, past experience if any using similar equipment, evaluation of upper extremity strength.
K0851	Power wheelchair, group 3 heavy-duty, captain's chair, patient weight capacity 301 to 450 pounds	Prior Authorization Required	Medical Necessity	Submit history and physical to include the following: diagnosis; abilities and limitations as they relate to the equipment (e.g., degree of independence/ dependence, frequency and nature of the activities the patient performs, duration of medical condition, past experience if any using similar equipment, evaluation of upper extremity strength.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
K0852	Power wheelchair, group 3 very heavy-duty, sling/solid seat/back, patient weight capacity 451 to 600 pounds	Prior Authorization Required	Medical Necessity	Submit history and physical to include the following: diagnosis; abilities and limitations as they relate to the equipment (e.g., degree of independence/ dependence, frequency and nature of the activities the patient performs, duration of medical condition, past experience if any using similar equipment, evaluation of upper extremity strength.
K0853	Power wheelchair, group 3 very heavy-duty, captain's chair, patient weight capacity 451 to 600 pounds	Prior Authorization Required	Medical Necessity	Submit history and physical to include the following: diagnosis; abilities and limitations as they relate to the equipment (e.g., degree of independence/ dependence, frequency and nature of the activities the patient performs, duration of medical condition, past experience if any using similar equipment, evaluation of upper extremity strength.
K0854	Power wheelchair, group 3 extra heavy-duty, sling/solid seat/back, patient weight capacity 601 pounds or more	Prior Authorization Required	Medical Necessity	Submit history and physical to include the following: diagnosis; abilities and limitations as they relate to the equipment (e.g., degree of independence/ dependence, frequency and nature of the activities the patient performs, duration of medical condition, past experience if any using similar equipment, evaluation of upper extremity strength.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
K0855	Power wheelchair, group 3 extra heavy duty, captain's chair, patient weight capacity 601 pounds or more	Prior Authorization Required	Medical Necessity	Submit history and physical to include the following: diagnosis; abilities and limitations as they relate to the equipment (e.g., degree of independence/ dependence, frequency and nature of the activities the patient performs, duration of medical condition, past experience if any using similar equipment, evaluation of upper extremity strength.
K0856	Power wheelchair, group 3 standard, single power option, sling/solid seat/back, patient weight capacity up to and including 300 pounds	Prior Authorization Required	Medical Necessity	Submit history and physical to include the following: diagnosis; abilities and limitations as they relate to the equipment (e.g., degree of independence/ dependence, frequency and nature of the activities the patient performs, duration of medical condition, past experience if any using similar equipment, evaluation of upper extremity strength.
K0857	Power wheelchair, group 3 standard, single power option, captain's chair, patient weight capacity up to and including 300 pounds	Prior Authorization Required	Medical Necessity	Submit history and physical to include the following: diagnosis; abilities and limitations as they relate to the equipment (e.g., degree of independence/ dependence, frequency and nature of the activities the patient performs, duration of medical condition, past experience if any using similar equipment, evaluation of upper extremity strength.

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K0858	Power wheelchair, group 3 heavy-duty, single power option, sling/solid seat/back, patient weight 301 to 450 pounds	Prior Authorization Required	Medical Necessity	Submit history and physical to include the following: diagnosis; abilities and limitations as they relate to the equipment (e.g., degree of independence/ dependence, frequency and nature of the activities the patient performs, duration of medical condition, past experience if any using similar equipment, evaluation of upper extremity strength.
K0859	Power wheelchair, group 3 heavy-duty, single power option, captain's chair, patient weight capacity 301 to 450 pounds	Prior Authorization Required	Medical Necessity	Submit history and physical to include the following: diagnosis; abilities and limitations as they relate to the equipment (e.g., degree of independence/ dependence, frequency and nature of the activities the patient performs, duration of medical condition, past experience if any using similar equipment, evaluation of upper extremity strength.
K0860	Power wheelchair, group 3 very heavy-duty, single power option, sling/solid seat/back, patient weight capacity 451 to 600 pounds	Prior Authorization Required	Medical Necessity	Submit history and physical to include the following: diagnosis; abilities and limitations as they relate to the equipment (e.g., degree of independence/ dependence, frequency and nature of the activities the patient performs, duration of medical condition, past experience if any using similar equipment, evaluation of upper extremity strength.

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K0861	Power wheelchair, group 3 standard, multiple power option, sling/solid seat/back, patient weight capacity up to and including 300 pounds	Prior Authorization Required	Medical Necessity	Submit history and physical to include the following: diagnosis; abilities and limitations as they relate to the equipment (e.g., degree of independence/ dependence, frequency and nature of the activities the patient performs, duration of medical condition, past experience if any using similar equipment, evaluation of upper extremity strength.
K0862	Power wheelchair, group 3 heavy-duty, multiple power option, sling/solid seat/back, patient weight capacity 301 to 450 pounds	Prior Authorization Required	Medical Necessity	Submit history and physical to include the following: diagnosis; abilities and limitations as they relate to the equipment (e.g., degree of independence/ dependence, frequency and nature of the activities the patient performs, duration of medical condition, past experience if any using similar equipment, evaluation of upper extremity strength.
K0863	Power wheelchair, group 3 very heavy-duty, multiple power option, sling/solid seat/back, patient weight capacity 451 to 600 pounds	Prior Authorization Required	Medical Necessity	Submit history and physical to include the following: diagnosis; abilities and limitations as they relate to the equipment (e.g., degree of independence/ dependence, frequency and nature of the activities the patient performs, duration of medical condition, past experience if any using similar equipment, evaluation of upper extremity strength.

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K0864	Power wheelchair, group 3 extra heavy-duty, multiple power option, sling/solid seat/back, patient weight capacity 601 pounds or more	Prior Authorization Required	Medical Necessity	Submit history and physical to include the following: diagnosis; abilities and limitations as they relate to the equipment (e.g., degree of independence/ dependence, frequency and nature of the activities the patient performs, duration of medical condition, past experience if any using similar equipment, evaluation of upper extremity strength.
K0868	Power wheelchair, group 4 standard, sling/solid seat/back, patient weight capacity up to and including 300 pounds	Prior Authorization Required	Medical Necessity	Submit history and physical to include the following: diagnosis; abilities and limitations as they relate to the equipment (e.g., degree of independence/ dependence, frequency and nature of the activities the patient performs, duration of medical condition, past experience if any using similar equipment, evaluation of upper extremity strength.
K0869	Power wheelchair, group 4 standard, captain's chair, patient weight capacity up to and including 300 pounds	Prior Authorization Required	Medical Necessity	Submit history and physical to include the following: diagnosis; abilities and limitations as they relate to the equipment (e.g., degree of independence/ dependence, frequency and nature of the activities the patient performs, duration of medical condition, past experience if any using similar equipment, evaluation of upper extremity strength.

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K0870	Power wheelchair, group 4 heavy-duty, sling/solid seat/back, patient weight capacity 301 to 450 pounds	Prior Authorization Required	Medical Necessity	Submit history and physical to include the following: diagnosis; abilities and limitations as they relate to the equipment (e.g., degree of independence/ dependence, frequency and nature of the activities the patient performs, duration of medical condition, past experience if any using similar equipment, evaluation of upper extremity strength.
K0871	Power wheelchair, group 4 very heavy-duty, sling/solid seat/back, patient weight capacity 451 to 600 pounds	Prior Authorization Required	Medical Necessity	Submit history and physical to include the following: diagnosis; abilities and limitations as they relate to the equipment (e.g., degree of independence/ dependence, frequency and nature of the activities the patient performs, duration of medical condition, past experience if any using similar equipment, evaluation of upper extremity strength.
K0877	Power wheelchair, group 4 standard, single power option, sling/solid seat/back, patient weight capacity up to and including 300 pounds	Prior Authorization Required	Medical Necessity	Submit history and physical to include the following: diagnosis; abilities and limitations as they relate to the equipment (e.g., degree of independence/ dependence, frequency and nature of the activities the patient performs, duration of medical condition, past experience if any using similar equipment, evaluation of upper extremity strength.

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K0878	Power wheelchair, group 4 standard, single power option, captain's chair, patient weight capacity up to and including 300 pounds	Prior Authorization Required	Medical Necessity	Submit history and physical to include the following: diagnosis; abilities and limitations as they relate to the equipment (e.g., degree of independence/ dependence, frequency and nature of the activities the patient performs, duration of medical condition, past experience if any using similar equipment, evaluation of upper extremity strength.
K0879	Power wheelchair, group 4 heavy-duty, single power option, sling/solid seat/back, patient weight capacity 301 to 450 pounds	Prior Authorization Required	Medical Necessity	Submit history and physical to include the following: diagnosis; abilities and limitations as they relate to the equipment (e.g., degree of independence/ dependence, frequency and nature of the activities the patient performs, duration of medical condition, past experience if any using similar equipment, evaluation of upper extremity strength.
K0880	Power wheelchair, group 4 very heavy-duty, single power option, sling/solid seat/back, patient weight 451 to 600 pounds	Prior Authorization Required	Medical Necessity	Submit history and physical to include the following: diagnosis; abilities and limitations as they relate to the equipment (e.g., degree of independence/ dependence, frequency and nature of the activities the patient performs, duration of medical condition, past experience if any using similar equipment, evaluation of upper extremity strength.

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K0884	Power wheelchair, group 4 standard, multiple power option, sling/solid seat/back, patient weight capacity up to and including 300 pounds	Prior Authorization Required	Medical Necessity	Submit history and physical to include the following: diagnosis; abilities and limitations as they relate to the equipment (e.g., degree of independence/ dependence, frequency and nature of the activities the patient performs, duration of medical condition, past experience if any using similar equipment, evaluation of upper extremity strength.
K0885	Power wheelchair, group 4 standard, multiple power option, captain's chair, patient weight capacity up to and including 300 pounds	Prior Authorization Required	Medical Necessity	Submit history and physical to include the following: diagnosis; abilities and limitations as they relate to the equipment (e.g., degree of independence/ dependence, frequency and nature of the activities the patient performs, duration of medical condition, past experience if any using similar equipment, evaluation of upper extremity strength.
K0886	Power wheelchair, group 4 heavy-duty, multiple power option, sling/solid seat/back, patient weight capacity 301 to 450 pounds	Prior Authorization Required	Medical Necessity	Submit history and physical to include the following: diagnosis; abilities and limitations as they relate to the equipment (e.g., degree of independence/ dependence, frequency and nature of the activities the patient performs, duration of medical condition, past experience if any using similar equipment, evaluation of upper extremity strength.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
K0890	Power wheelchair, group 5 pediatric, single power option, sling/solid seat/back, patient weight capacity up to and including 125 pounds	Prior Authorization Required	Medical Necessity	Submit history and physical to include the following: diagnosis; abilities and limitations as they relate to the equipment (e.g., degree of independence/ dependence, frequency and nature of the activities the patient performs, duration of medical condition, past experience if any using similar equipment, evaluation of upper extremity strength.
K0891	Power wheelchair, group 5 pediatric, multiple power option, sling/solid seat/back, patient weight capacity up to and including 125 pounds	Prior Authorization Required	Medical Necessity	Submit history and physical to include the following: diagnosis; abilities and limitations as they relate to the equipment (e.g., degree of independence/ dependence, frequency and nature of the activities the patient performs, duration of medical condition, past experience if any using similar equipment, evaluation of upper extremity strength.
K0898	Power wheelchair, not otherwise classified	Prior Authorization Required	Medical Necessity	Submit history and physical to include the following: diagnosis; abilities and limitations as they relate to the equipment (e.g., degree of independence/ dependence, frequency and nature of the activities the patient performs, duration of medical condition, past experience if any using similar equipment, evaluation of upper extremity strength.
K0899	Power mobility device, not coded by DME PDAC or does not meet criteria	Prior Authorization Required	Medical Necessity	Submit letter of medical necessity including length of time equipment needed, functional status if applicable and description of medical condition.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
K0900	Customized durable medical equipment, other than wheelchair	Prior Authorization Required	Specialized DME	History and Physical to Include the following: diagnosis; abilities and limitations as they relate to the equipment (e.g., degree of independence/ dependence, frequency and nature of the activities the patient performs, duration of medical condition, Past experience if any using similar equipment, Evaluation of upper extremity strength. Include invoice of cost for item.
K1003	Whirlpool tub, walk-in, portable	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
K1004	Low frequency ultrasonic diathermy treatment device for home use	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
K1007	Bilateral hip, knee, ankle, foot device, powered, includes pelvic component, single or double upright(s), knee joints any type, with or without ankle joints any type, includes all components and accessories, motors, microprocessors, sensors	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
K1027	Oral device/appliance used to reduce upper airway collapsibility, without fixed mechanical hinge, custom fabricated, includes fitting and adjustment	Prior Authorization Required	Sleep Devices and Equipment	Compliance information is required for sleep apnea equipment supplies. Submit online review with Carelon at www.providerportal.com during rental period. Post rental period and diagnosis other than sleep apnea, no review required.
K1036	Supplies and accessories (eg, transducer) for low frequency ultrasonic diathermy treatment device, per month	Possible Denial; Medical Records Optional	Investigative	Documentation optional.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
K1037	Docking station for use with oral device/appliance used to reduce upper airway collapsibility	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
L1834	Knee orthotic (KO), without knee joint, rigid, custom fabricated	Prior Authorization Required	Medical Necessity	Submit letter of medical necessity including length of time equipment needed, functional status if applicable and description of medical condition.
L1840	Derotation, medial-lateral, anterior cruciate ligament, custom-fabricated	Prior Authorization Required	Medical Necessity	Submit letter of medical necessity including length of time equipment needed, functional status if applicable and description of medical condition.
L1844	Knee orthotic (KO), single upright, thigh and calf, with adjustable flexion and extension joint (unicentric or polycentric), medial-lateral and rotation control, with or without varus/valgus adjustment, custom fabricated	Prior Authorization Required	Medical Necessity	Submit letter of medical necessity including length of time equipment needed, functional status if applicable and description of medical condition.
L1846	Knee orthotic, double upright, thigh and calf, with adjustable flexion and extension joint (unicentric or polycentric), medial-lateral and rotation control, with or without varus/valgus adjustment, custom fabricated	Prior Authorization Required	Medical Necessity	Submit letter of medical necessity including length of time equipment needed, functional status if applicable and description of medical condition.
L1860	Knee orthosis, modification of supracondylar prosthetic socket, custom fabricated (SK)	Prior Authorization Required	Medical Necessity	Submit letter of medical necessity including length of time equipment needed, functional status if applicable and description of medical condition.
L1945	Ankle-foot orthotic (AFO), plastic, rigid anterior tibial section (floor reaction), custom fabricated	Prior Authorization Required	Medical Necessity	Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
L2006	Knee-ankle-foot (KAF) device, any material, single or double upright, swing and/or stance phase microprocessor control with adjustability, includes all components (e.g., sensors, batteries, charger), any type activation, with or without ankle joint(s), custom fabricated	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
L2755	Addition to lower extremity orthotic, high strength, lightweight material, all hybrid lamination/prepreg composite, per segment, for custom fabricated orthotic only	Prior Authorization Required	Medical Necessity	Submit letter of medical necessity including length of time equipment needed, functional status if applicable and description of medical condition.
L5615	Additional, endoskeletal knee-shin system, 4 bar linkage or multiaxial, fluid swing and stance phase control	Prior Authorization Required	Medical Necessity	Submit letter of medical necessity including length of time equipment needed, functional status if applicable and description of medical condition.
L5827	Endoskeletal knee-shin system, single axis, electromechanical swing and stance phase control, with or without shock absorption and stance extension damping	Possible Denial; Medical Records Optional	Medical Necessity	Documentation optional.
L5856	Addition to lower extremity prosthesis, endoskeletal knee-shin system, microprocessor control feature, swing and stance phase, includes electronic sensor(s), any type	Prior Authorization Required	Medical Necessity	Submit letter of medical necessity including length of time equipment needed, functional status if applicable and description of medical condition.
L5857	Addition to lower extremity prosthesis, endoskeletal knee-shin system, microprocessor control feature, swing phase only, includes electronic sensor(s), any type	Prior Authorization Required	Medical Necessity	Submit letter of medical necessity including length of time equipment needed, functional status if applicable and description of medical condition.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
L5858	Addition to lower extremity prosthesis, endoskeletal knee shin system, microprocessor control feature, stance phase only, includes electronic sensor(s), any type	Prior Authorization Required	Medical Necessity	Submit letter of medical necessity including length of time equipment needed, functional status if applicable and description of medical condition.
L5859	Addition to lower extremity prosthesis, endoskeletal knee-shin system, powered and programmable flexion/extension assist control, includes any type motor(s)	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
L5969	Addition, endoskeletal ankle-foot or ankle system, power assist, includes any type motor(s)	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
L5973	Endoskeletal ankle foot system, microprocessor controlled feature, dorsiflexion and/or plantar flexion control, includes power source	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
L5991	Addition to lower extremity prosthesis, osseointegrated external prosthetic connector	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
L6026	Transcarpal/metacarpal or partial hand disarticulation prosthesis, external power, self-suspended, inner socket with removable forearm section, electrodes and cables, two batteries, charger, myoelectric control of terminal device, excludes terminal device(s)	Prior Authorization Required	Medical Necessity	History and physical, letter of medical necessity and functional status eval from physiatrist or physical therapist.
L6700	Upper extremity addition, external powered feature, myoelectronic control module, additional emg inputs, pattern-recognition decoding intent movement	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
L6715	Terminal device, multiple articulating digit, includes motor(s), initial issue or replacement	Prior Authorization Required	Medical Necessity	History and Physical, physiatrist documentation of physical capacity

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
L6880	Electric hand, switch or myolelectric controlled, independently articulating digits, any grasp pattern or combination of grasp patterns, includes motor(s)	Prior Authorization Required	Medical Necessity	History and Physical, physiatrist documentation of physical capacity
L6895	Addition to upper extremity prosthesis, glove for terminal device, any material, custom fabricated	Prior Authorization Required	Medical Necessity	History and Physical, physiatrist documentation of physical capacity
L6925	Wrist disarticulation, external power, self-suspended inner socket, removable forearm shell, Otto Bock or equal electrodes, cables, 2 batteries and one charger, myoelectronic control of terminal device	Prior Authorization Required	Medical Necessity	History and physical, letter of medical necessity and functional status eval from physiatrist or physical therapist.
L6935	Below elbow, external power, self-suspended inner socket, removable forearm shell, Otto Bock or equal electrodes, cables, 2 batteries and one charger, myoelectronic control of terminal device	Prior Authorization Required	Medical Necessity	History and physical, letter of medical necessity and functional status eval from physiatrist or physical therapist.
L6945	Elbow disarticulation, external power, molded inner socket, removable humeral shell, outside locking hinges, forearm, Otto Bock or equal electrodes, cables, 2 batteries and one charger, myoelectronic control of terminal device	Prior Authorization Required	Medical Necessity	History and physical, letter of medical necessity and functional status eval from physiatrist or physical therapist.
L6955	Above elbow, external power, molded inner socket, removable humeral shell, internal locking elbow, forearm, Otto Bock or equal electrodes, cables, 2 batteries and one charger, myoelectronic control of terminal device	Prior Authorization Required	Medical Necessity	History and physical, letter of medical necessity and functional status eval from physiatrist or physical therapist.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
L6965	Shoulder disarticulation, external power, molded inner socket, removable shoulder shell, shoulder bulkhead, humeral section, mechanical elbow, forearm, Otto Bock or equal electrodes, cables, 2 batteries and one charger, myoelectronic control of terminal device	Prior Authorization Required	Medical Necessity	History and physical, letter of medical necessity and functional status eval from physiatrist or physical therapist.
L6975	Interscapular-thoracic, external power, molded inner socket, removable shoulder shell, shoulder bulkhead, humeral section, mechanical elbow, forearm, Otto Bock or equal electrodes, cables, 2 batteries and one charger, myoelectronic control of terminal device	Prior Authorization Required	Medical Necessity	History and physical, letter of medical necessity and functional status eval from physiatrist or physical therapist.
L7007	Electric hand, switch or myoelectric controlled, adult	Prior Authorization Required	Medical Necessity	History and physical, letter of medical necessity and functional status eval from physiatrist or physical therapist.
L7008	Electric hand, switch or myoelectric, controlled, pediatric	Prior Authorization Required	Medical Necessity	History and physical, letter of medical necessity and functional status eval from physiatrist or physical therapist.
L7009	Electric hook, switch or myoelectric controlled, adult	Prior Authorization Required	Medical Necessity	History and physical, letter of medical necessity and functional status eval from physiatrist or physical therapist.
L7045	Electric hook, switch or myoelectric controlled, pediatric	Prior Authorization Required	Medical Necessity	History and physical, letter of medical necessity and functional status eval from physiatrist or physical therapist.
L7180	Electronic elbow, microprocessor sequential control of elbow and terminal device	Prior Authorization Required	Medical Necessity	Letter of Medical Necessity from Physiatrist or Occupational Therapist, including functional status and assessment of rehab potential
L7181	Electronic elbow, microprocessor simultaneous control of elbow and terminal device	Prior Authorization Required	Medical Necessity	Letter of Medical Necessity from Physiatrist or Occupational Therapist, including functional status and assessment of rehab potential

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L7190	Electronic elbow, adolescent, Variety Village or equal, myoelectronically controlled	Prior Authorization Required	Medical Necessity	History and physical, letter of medical necessity and functional status eval from physiatrist or physical therapist.
L7191	Electronic elbow, child, Variety Village or equal, myoelectronically controlled	Prior Authorization Required	Medical Necessity	History and physical, letter of medical necessity and functional status eval from physiatrist or physical therapist.
L7259	Electronic wrist rotator, any type	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
L7499	Upper extremity prosthesis, not otherwise specified	Medical necessity review will be performed upon claims submission with supporting documentation.	Medical Necessity	Review required at claims submission; submit description of procedure with supporting documentation (including operative report if surgical) only for the date of service performed.
L7900	Male vacuum erection system	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
L8300	Truss, single with standard pad	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
L8310	Truss, double with standard pads	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
L8320	Truss, addition to standard pad, water pad	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
L8330	Truss, addition to standard pad, scrotal pad	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
L8600	Implantable breast prosthesis, silicone or equal	Pre-Service Review Required	Medical Necessity	Pre Operative Evaluation, History and Physical, and Operative report.
L8608	Miscellaneous external component, supply or accessory for use with the Argus II Retinal Prosthesis System	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
L8614	Cochlear device, includes all internal and external components	Prior Authorization Required	Medical Necessity	Pre Operative Evaluation, Operative Report, Previous use of hearing aids, Level of hearing Impairment
L8619	Cochlear implant external speech processor, replacement	Prior Authorization Required	Medical Necessity	Pre Operative Evaluation, Operative Report, Previous use of hearing aids, Level of hearing Impairment

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
L8679	Implantable neurostimulator, pulse generator, any type	Prior Authorization Required	Medical Necessity	Submit letter of medical necessity including length of time equipment needed, functional status if applicable and description of medical condition.
L8680	Implantable neurostimulator electrode, each	Prior Authorization Required	Medical Necessity	Recent History and Physical, plan of care, and documentation of medical necessity
L8681	Patient programmer (external) for use with implantable programmable neurostimulator pulse generator, replacement only	Prior Authorization Required	Medical Necessity	Submit letter of medical necessity including length of time equipment needed, functional status if applicable and description of medical condition.
L8682	Implantable neurostimulator radiofrequency receiver	Prior Authorization Required	Medical Necessity	Submit letter of medical necessity including length of time equipment needed, functional status if applicable and description of medical condition.
L8683	Radiofrequency transmitter (external) for use with implantable neurostimulator radiofrequency receiver	Prior Authorization Required	Medical Necessity	Submit letter of medical necessity including length of time equipment needed, functional status if applicable and description of medical condition.
L8684	Radiofrequency transmitter (external) for use with implantable sacral root neurostimulator receiver for bowel and bladder management, replacement	Prior Authorization Required	Medical Necessity	Submit letter of medical necessity including length of time equipment needed, functional status if applicable and description of medical condition.
L8685	Implantable neurostimulator pulse generator, single array, rechargeable, includes extension	Prior Authorization Required	Medical Necessity	Submit letter of medical necessity including length of time equipment needed, functional status if applicable and description of medical condition.
L8686	Implantable neurostimulator pulse generator, single array, nonrechargeable, includes extension	Prior Authorization Required	Medical Necessity	Submit letter of medical necessity including length of time equipment needed, functional status if applicable and description of medical condition.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
L8687	Implantable neurostimulator pulse generator, dual array, rechargeable, includes extension	Prior Authorization Required	Medical Necessity	Submit letter of medical necessity including length of time equipment needed, functional status if applicable and description of medical condition.
L8688	Implantable neurostimulator pulse generator, dual array, nonrechargeable, includes extension	Prior Authorization Required	Medical Necessity	Submit letter of medical necessity including length of time equipment needed, functional status if applicable and description of medical condition.
L8689	External recharging system for battery (internal) for use with implantable neurostimulator, replacement only	Prior Authorization Required	Medical Necessity	Submit letter of medical necessity including length of time equipment needed, functional status if applicable and description of medical condition.
L8690	Auditory osseointegrated device, includes all internal and external components	Prior Authorization Required	Medical Necessity	Pre Operative Evaluation, Operative Report, Previous use of hearing aids, Level of hearing Impairment
L8691	Auditory osseointegrated device, external sound processor, replacement	Prior Authorization Required	Medical Necessity	Pre Operative Evaluation, Operative Report, Previous use of hearing aids, Level of hearing Impairment
L8693	Auditory osseointegrated device abutment, any length, replacement only	Prior Authorization Required	Medical Necessity	Pre Operative Evaluation, Operative Report, Previous use of hearing aids, Level of hearing Impairment
L8694	Auditory osseointegrated device, transducer/actuator, replacement only, each	Prior Authorization Required	Medical Necessity	Submit pre-operative evaluation, operative report, previous use of hearing aids, level of hearing Impairment
L8699	Prosthetic implant, not otherwise specified	Retrospective Review	Medical Necessity	Submit the description of an item provided, cost invoice and a letter of medical necessity from the ordering physician. No invoice needed if pricing is not required.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
L8701	Powered upper extremity range of motion assist device, elbow, wrist, hand with single or double upright(s), includes microprocessor, sensors, all components and accessories, custom fabricated	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
L8702	Powered upper extremity range of motion assist device, elbow, wrist, hand, finger, single or double upright(s), includes microprocessor, sensors, all components and accessories, custom fabricated	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
L8720	External lower extremity sensory prosthesis, cutaneous stimulation of mechanoreceptors proximal to the ankle, per leg	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
L8721	Receptor sole for use with l8720, replacement, each	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
M0076	Prolotherapy	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
M0224	Intravenous infusion, pemivibart, for the pre-exposure prophylaxis only, for certain adults and adolescents (12 years of age and older weighing at least 40 kg) with no known SARS-CoV-2 exposure, who either have moderate-to-severe immune compromise due to a medical condition or receipt of immunosuppressive medications or treatments, includes infusion and post administration monitoring	Non-covered Service	Not Covered	This service is not covered by the member's contract.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
M0249	Intravenous infusion, tocilizumab, for hospitalized adults and pediatric patients (2 years of age and older) with COVID-19 who are receiving systemic corticosteroids and require supplemental oxygen, non-invasive or invasive mechanical ventilation, or extracorporeal membrane oxygenation (ECMO) only, includes infusion and post administration monitoring, first dose	Non-covered Service	Not Covered	This service is not covered by the member's contract.
M0250	Intravenous infusion, tocilizumab, for hospitalized adults and pediatric patients (2 years of age and older) with COVID-19 who are receiving systemic corticosteroids and require supplemental oxygen, non-invasive or invasive mechanical ventilation, or extracorporeal membrane oxygenation (ECMO) only, includes infusion and post administration monitoring, second dose	Non-covered Service	Not Covered	This service is not covered by the member's contract.
P2031	Hair analysis (excluding arsenic	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
P9020	Platelet rich plasma, each unit	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
P9027	Red blood cells, leukocytes reduced, oxygen/ carbon dioxide reduced, each unit	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
Q0138	Injection, ferumoxytol, for treatment of iron deficiency anemia, 1 mg (non-ESRD use)	Prior Authorization Required	Investigative	Submit history and physical, documentation of medical necessity.
Q0139	Injection, ferumoxytol, for treatment of iron deficiency anemia, 1 mg (for ESRD on dialysis)	Prior Authorization Required	Investigative	Submit history and physical, documentation of medical necessity.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
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	Medical necessity review will be performed upon claims submission with supporting documentation.	Medical Necessity	Review required at claims submission; submit description of procedure with supporting documentation (including operative report if surgical) only for the date of service performed.
Q0224	Injection, pemivibart, for the pre-exposure prophylaxis only, for certain adults and adolescents (12 years of age and older weighing at least 40 kg) with no known SARS-CoV-2 exposure, and who either have moderate-to-severe immune compromise due to a medical condition or receipt of immunosuppressive medications or treatments, and are unlikely to mount an adequate immune response to COVID-19 vaccination, 4500 mg	Non-covered Service	Not Covered	This service is not covered by the member's contract.
Q0249	Injection, tocilizumab, for hospitalized adults and pediatric patients (2 years of age and older) with COVID-19 who are receiving systemic corticosteroids and require supplemental oxygen, non-invasive or invasive mechanical ventilation, or extracorporeal membrane oxygenation (ECMO) only, 1 mg	Non-covered Service	Not Covered	This service is not covered by the member's contract.
Q2026	Injection, Radiesse, 0.1ML	Possible Denial; Medical Records Optional	Cosmetic	Clinical notes from doctor's office related to this condition and treatment
Q2028	Injection, sculptra, 0.5 mg	Possible Denial; Medical Records Optional	Cosmetic	Clinical notes from doctor's office related to this condition and treatment

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
Q2041	Axicabtagene ciloleucel, up to 200 million autologous anti-cd19 car positive viable t cells, including leukapheresis and dose preparation procedures, per therapeutic dose	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
Q2042	Tisagenlecleucel, up to 600 million car-positive viable t cells, including leukapheresis and dose preparation procedures, per therapeutic dose	Prior Authorization Required	Medical Necessity	Submit History and Physical, documentation of medical necessity, operative report
Q2043	Sipuleucel-t, minimum of 50 million autologous cd54+ cells activated with pap-gm-csf, including leukapheresis and all other preparatory procedures, per infusion	Prior Authorization Required	Medical Necessity	History and physical, clinical notes related to a condition being treated, treatment plan.
Q2053	Brexucabtagene autoleucel, up to 200 million autologous anti-cd19 car positive viable t cells, including leukapheresis and dose preparation procedures, per therapeutic dose	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
Q2054	Lisocabtagene maraleucel, up to 110 million autologous anti-CD19 CAR-positive viable T cells, including leukapheresis and dose preparation procedures, per therapeutic dose	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
Q2055	Idecabtagene vicleucel, up to 460 million autologous B-cell maturation antigen (BCMA) directed CAR-positive T cells, including leukapheresis and dose preparation procedures, per therapeutic dose	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
Q2056	Ciltacabtagene autoleucel, up to 100 million autologous B-cell maturation antigen (BCMA) directed CAR-positive T cells, including leukapheresis and dose preparation procedures, per therapeutic dose	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
Q2057	Afamitresgene autoleucel, including leukapheresis and dose preparation procedures, per therapeutic dose	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
Q3001	Radioelements for brachytherapy, any type, each	Prior Authorization Required	Radiation Oncology	No review for non-cancer diagnoses. FOR CANCER DIAGNOSES ONLY: Submit online review with Carelon at www.providerportal.com. For prior authorization include history and physical, results of previous diagnostics procedure report.
Q3027	Injection, interferon beta-1a, 1 mcg for intramuscular use	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, treatment plan
Q3028	Injection, interferon beta-1a, 1 mcg for subcutaneous use	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, treatment plan
Q4074	Iloprost, inhalation solution, FDA-approved final product, noncompounded, administered through DME, unit dose form, up to 20 mcg	Prior Authorization Required	Medical Necessity	History and physical, office notes related to a condition being treated.
Q4081	Injection, epoetin alfa, 100 units (for ESRD on dialysis)	Prior Authorization Required	Medical Necessity	Submit chart notes from the ordering physician including history and physical with Hgb level and transferrin saturation or ferritin level within 1 month of initiating ESA and monthly.

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Q4100	Skin substitute, not otherwise specified	Medical necessity review will be performed upon claims submission with supporting documentation.	Medical Necessity	Upon claims submission Medical necessity review will be performed. Submit documentation to describe the services. Include history and physical, procedure report and rationale for use of this product.
Q4103	Oasis burn matrix, per sq cm	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
Q4104	Integra bilayer matrix wound dressing (BMWD), per sq cm	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
Q4108	Integra matrix, per sq cm	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
Q4110	PriMatrix, per sq cm	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
Q4111	GammaGraft, per sq cm	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
Q4112	Cymetra, injectable, 1 cc	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
Q4113	GRAFTJACKET XPRESS, injectable, 1cc	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
Q4115	AlloSkin, per sq cm	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
Q4117	HYALOMATRIX, per sq cm	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
Q4118	MatriStem micromatrix, 1 mg	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
Q4121	TheraSkin, per sq cm	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
Q4123	AlloSkin RT, per sq cm	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
Q4124	OASIS ultra tri-layer wound matrix, per sq cm	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
Q4125	Arthroflex, per sq cm	Possible Denial; Medical Records Optional	Investigative	Documentation optional.

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Q4126	MemoDerm, DermaSpan, TranZgraft or InteguPly, per sq cm	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
Q4127	Talymed, per sq cm	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
Q4130	Strattice TM, per sq cm	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
Q4132	Grafix Core, per sq cm	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
Q4133	Grafix prime, grafixpl prime, stravix and stravixpl, per square centimeter	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
Q4134	HMatrix, per sq cm	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
Q4135	Mediskin, per sq cm	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
Q4136	E-Z Derm, per sq cm	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
Q4137	Amnioexcel, amnioexcel plus or biodexcel, per square centimeter	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
Q4138	BioDFence DryFlex, per sq cm	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
Q4139	Amniomatrix or biodmatrix, injectable, 1 cc	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
Q4140	BioDFence, per sq cm	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
Q4141	AlloSkin AC, per sq cm	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
Q4142	XCM biologic tissue matrix, per sq cm	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
Q4143	Repriza, per sq cm	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
Q4145	EpiFix, injectable, 1 mg	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
Q4146	Tensix, per sq cm	Possible Denial; Medical Records Optional	Investigative	Documentation optional.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
Q4147	Architect, Architect PX, or Architect FX, extracellular matrix, per sq cm	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
Q4148	Neox 1k, per sq cm	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
Q4149	Excellagen, 0.1 cc	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
Q4150	AlloWrap DS or dry, per sq cm	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
Q4151	AmnioBand or Guardian, per sq cm	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
Q4152	DermaPure, per sq cm	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
Q4153	Dermavest and Plurivest, per sq cm	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
Q4154	Biovance, per sq cm	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity and procedure report.
Q4155	Neox Flo or Clarix Flo 1 mg	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
Q4156	Neox 100, per sq cm	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
Q4157	Revitalon, per sq cm	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
Q4158	Kerecis Omega3, per sq cm	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
Q4159	Affinity, per sq cm	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity and procedure report.
Q4160	Nushield, per sq cm	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
Q4161	Bio-ConneKt wound matrix, per sq cm	Possible Denial; Medical Records Optional	Investigative	Documentation optional.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
Q4162	AmnioPro Flow, BioSkin Flow, BioRenew Flow, WoundEx Flow, Amniogen-A, Amniogen-C, 0.5 cc	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
Q4163	AmnioPro, BioSkin, BioRenew, WoundEx, Amniogen-45, Amniogen-200, per sq cm	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
Q4164	Helicoll, per sq cm	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
Q4165	Keramatrix or Kerasorb, per sq cm	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
Q4166	Cytal, per sq cm	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
Q4167	Truskin, per sq cm	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
Q4168	AmnioBand, 1 mg	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
Q4169	Artacent wound, per sq cm	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
Q4170	Cygnus, per sq cm	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
Q4171	Interfyl, 1 mg	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
Q4173	PalinGen or PalinGen XPlus, per sq cm	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
Q4174	PalinGen or ProMatrX, 0.36 mg per 0.25 cc	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
Q4175	Miroderm, per sq cm	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
Q4176	Neopatch or Therion, per square centimeter	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
Q4177	FlowerAmnioFlo, 0.1 cc	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
Q4178	FlowerAmnioPatch, per sq cm	Possible Denial; Medical Records Optional	Investigative	Documentation optional.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
Q4179	FlowerDerm, per sq cm	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
Q4180	Revita, per sq cm	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
Q4181	Amnio Wound, per sq cm	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
Q4182	Transcyte, per sq cm	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
Q4183	Surgigraft, per square centimeter	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
Q4184	Cellesta or Cellesta Duo, per square centimeter	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
Q4185	Cellesta flowable amnion (25 mg per cc); per 0.5 cc	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
Q4186	Epifix, per square centimeter	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
Q4187	Epicord, per sq cm	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
Q4188	Amnioarmor, per square centimeter	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
Q4189	Artacent ac, 1 mg	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
Q4190	Artacent AC, per sq cm	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
Q4191	Restorigin, per square centimeter	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
Q4192	Restorigin, 1 cc	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
Q4193	Coll-e-derm, per square centimeter	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
Q4194	Novachor, per square centimeter	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
Q4195	Puraply, per square centimeter	Possible Denial; Medical Records Optional	Investigative	Documentation optional.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
Q4196	Puraply am, per square centimeter	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
Q4197	Puraply xt, per square centimeter	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
Q4198	Genesis amniotic membrane, per square centimeter	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
Q4199	Cygnus matrix, per sq cm	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
Q4200	Skin te, per square centimeter	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
Q4201	Matrion, per square centimeter	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
Q4202	Keroxx (2.5g/cc), 1cc	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
Q4203	Derma-gide, per square centimeter	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
Q4204	Xwrap, per square centimeter	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
Q4205	Membrane Graft or Membrane Wrap, per sq cm	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
Q4206	Fluid Flow or Fluid GF, 1 cc	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
Q4208	Novafix, per sq cm	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
Q4209	SurGraft, per sq c	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
Q4211	Amnion Bio or AxoBioMembrane, per sq cm	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
Q4212	AlloGen, per cc	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
Q4213	Ascent, 0.5 mg	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
Q4214	Cellesta Cord, per sq cm	Possible Denial; Medical Records Optional	Investigative	Documentation optional.

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Q4215	Axolotl Ambient or Axolotl Cryo, 0.1 mg	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
Q4216	Artacent Cord, per sq cm	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
Q4217	WoundFix, BioWound, WoundFix Plus, BioWound Plus, WoundFix Xplus or BioWound Xplus, per sq cm	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
Q4218	SurgiCORD, per sq cm	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
Q4219	SurgiGRAFT-DUAL, per sq cm	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
Q4220	BellaCell HD or Surederm, per sq cm	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
Q4221	Amnio Wrap2, per sq cm	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
Q4222	ProgenaMatrix, per sq cm	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
Q4224	Human Health Factor 10 amniotic patch (hhf10-p), per square centimeter	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
Q4225	AmnioBind, per square centimeter	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
Q4226	MyOwn Skin, includes harvesting and preparation procedures, per sq cm	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
Q4227	AmnioCoreTM, per sq cm	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
Q4229	Cogenex Amniotic Membrane, per sq cm	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
Q4230	Cogenex Flowable Amnion, per 0.5 cc	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
Q4231	Corplex P, per cc	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
Q4232	Corplex, per sq cm	Possible Denial; Medical Records Optional	Investigative	Documentation optional.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
Q4233	SurFactor or NuDyn, per 0.5 cc	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
Q4234	XCellerate, per sq cm	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
Q4235	AMNIOREPAIR or AltiPly, per sq cm	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
Q4236	carePATCH, per sq cm	Pre-Service Review Required	Investigative	Documentation optional.
Q4237	Cryo-Cord, per sq cm	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
Q4238	Derm-Maxx, per sq cm	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
Q4239	Amnio-Maxx or Amnio-Maxx Lite, per sq cm	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
Q4240	CoreCyte, for topical use only, per 0.5 cc	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
Q4241	PolyCyte, for topical use only, per 0.5 cc	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
Q4242	AmnioCyte Plus, per 0.5 cc	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
Q4245	AmnioText, per cc	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
Q4246	CoreText or ProText, per cc	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
Q4247	Amniotext patch, per sq cm	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
Q4248	Dermacyte Amniotic Membrane Allograft, per sq cm	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
Q4249	AMNIPLY, for topical use only, per sq cm	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
Q4250	AmnioAmp-MP, per sq cm	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
Q4251	Vim, per sq cm	Possible Denial; Medical Records Optional	Investigative	Documentation optional.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
Q4252	Vendaje, per sq cm	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
Q4253	Zenith Amniotic Membrane, per sq cm	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
Q4254	NovaFix DL, per sq cm	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
Q4255	REGUaRD, for topical use only, per sq cm	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
Q4256	MLG-Complete, per square centimeter	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
Q4257	Relese, per square centimeter	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
Q4258	Enverse, per square centimeter	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
Q4259	Celera Dual Layer or Celera Dual Membrane, per sq cm	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
Q4260	Signature APatch, per sq cm	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
Q4261	TAG, per sq cm	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
Q4262	Dual Layer Impax Membrane, per sq cm	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
Q4263	SurGraft TL, per sq cm	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
Q4264	Cocoon Membrane, per sq cm	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
Q4265	NeoStim TL, per square centimeter	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
Q4266	NeoStim Membrane, per square centimeter	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
Q4267	NeoStim DL, per square centimeter	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
Q4268	SurGraft FT, per square centimeter	Possible Denial; Medical Records Optional	Investigative	Documentation optional.

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Q4269	SurGraft XT, per square centimeter	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
Q4270	Complete SL, per square centimeter	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
Q4271	Complete FT, per square centimeter	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
Q4272	Esano a, per square centimeter	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
Q4273	Esano aaa, per square centimeter	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
Q4274	Esano ac, per square centimeter	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
Q4275	Esano aca, per square centimeter	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
Q4276	Orion, per square centimeter	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
Q4278	Epieffect, per square centimeter	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
Q4279	Vendaje ac, per square centimeter	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
Q4280	Xcell amnio matrix, per square centimeter	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
Q4281	Barrera sl or Barrera dl, per square centimeter	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
Q4282	Cygnus dual, per square centimeter	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
Q4283	Biovance tri-layer or Biovance 3l, per square centimeter	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
Q4284	Dermabind sl, per square centimeter	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
Q4285	Nudyn DL or Nudyn DL mesh, per square centimeter	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
Q4286	Nudyn SL or Nudyn SLW, per square centimeter	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.

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Q4287	Dermabind dl, per square centimeter	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
Q4288	Dermabind ch, per square centimeter	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
Q4289	Revoshield + amniotic barrier, per square centimeter	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
Q4290	Membrane wrap-hydro, per square centimeter	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
Q4291	Lamellas xt, per square centimeter	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
Q4292	Lamellas, per square centimeter	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
Q4293	Acesso dl, per square centimeter	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
Q4294	Amino quad-core, per square centimeter	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
Q4295	Amnio tri-core amniotic, per square centimeter	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
Q4296	Rebound matrix, per square centimeter	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
Q4297	Emerge matrix, per square centimeter	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
Q4298	Amniocore pro, per square centimeter	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
Q4299	Amniocore pro +, per square centimeter	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
Q4300	Acesso tl, per square centimeter	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
Q4301	Activate matrix, per square centimeter	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
Q4302	Complete aca, per square centimeter	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
Q4303	Complete aa, per square centimeter	Possible Denial; Medical Records Optional	Investigative	Documentation optional.

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Q4304	Grafix plus, per square centimeter	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
Q4305	American amnion ac tri-layer, per square centimeter	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
Q4306	American amnion ac, per square centimeter	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
Q4307	American amnion, per square centimeter	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
Q4308	Sanopellis, per square centimeter	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
Q4309	Via matrix, per square centimeter	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
Q4310	Procenta, per 100 mg	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
Q4311	Acesso, per square centimeter	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
Q4312	Acesso ac, per square centimeter	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
Q4313	Dermabind fm, per square centimeter	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
Q4314	Reeva ft, per square cenitmeter	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
Q4315	Regenelink amniotic membrane allograft, per square centimeter	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
Q4316	Amchoplast, per square centimeter	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
Q4317	Vitograft, per square centimeter	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
Q4318	E-graft, per square centimeter	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
Q4319	Sanograft, per square centimeter	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
Q4320	Pellograft, per square centimeter	Possible Denial; Medical Records Optional	Investigative	Documentation optional.

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Q4321	Renograft, per square centimeter	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
Q4322	Caregraft, per square centimeter	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
Q4323	Alloply, per square centimeter	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
Q4324	Amniotx, per square centimeter	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
Q4325	Acapatch, per square centimeter	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
Q4326	Woundplus, per square centimeter	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
Q4327	Duoamnion, per square centimeter	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
Q4328	Most, per square centimeter	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
Q4329	Singlay, per square centimeter	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
Q4330	Total, per square centimeter	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
Q4331	Axolotl graft, per square centimeter	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
Q4332	Axolotl dualgraft, per square centimeter	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
Q4333	Ardeograft, per square centimeter	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
Q4334	Amnioplast 1, per square centimeter	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
Q4335	Amnioplast 2, per square centimeter	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
Q4336	Artacent c, per square centimeter	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
Q4337	ARTACENT TRIDENT, PER SQUARE CENTIMETER	Possible Denial; Medical Records Optional	Investigative	Documentation optional.

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Q4338	Artacent velos, per square centimeter	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
Q4339	Artacent vericlen, per square centimeter	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
Q4340	Simpligraft, per square centimeter	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
Q4341	Simplimax, per square centimeter	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
Q4342	Theramend, per square centimeter	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
Q4343	Dermacyte ac matrix amniotic membrane allograft, per square centimeter	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
Q4344	Tri-membrane wrap, per square centimeter	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
Q4345	Matrix hd allograft dermis, per square centimeter	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
Q4346	Shelter dm matrix, per square centimeter	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
Q4347	Rampart dl matrix, per square centimeter	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
Q4348	Sentry sl matrix, per square centimeter	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
Q4349	Mantle dl matrix, per square centimeter	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
Q4350	Palisade dm matrix, per square centimeter	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
Q4351	Enclose tl matrix, per square centimeter	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
Q4352	Overlay sl matrix, per square centimeter	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
Q4353	Xceed tl matrix, per square centimeter	Possible Denial; Medical Records Optional	Investigative	Documentation optional.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
Q4354	Palingen dual-layer membrane, per square centimeter	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
Q4355	Abiomend xplus membrane and abiomend xplus hydromembrane, per square centimeter	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
Q4356	Abiomend membrane and abiomend hydromembrane, per square centimeter	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
Q4357	Xwrap plus, per square centimeter	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
Q4358	Xwrap dual, per square centimeter	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
Q4359	Choriply, per square centimeter	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
Q4360	Amchoplast fd, per square centimeter	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
Q4361	Epixpress, per square centimeter	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
Q4362	Cygnus disk, per square centimeter	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
Q4363	Amnio burgeon membrane and hydromembrane, per square centimeter	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
Q4364	Amnio burgeon xplus membrane and xplus hydromembrane, per square centimeter	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
Q4365	Amnio burgeon dual-layer membrane, per square centimeter	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
Q4366	Dual layer amnio burgeon x-membrane, per square centimeter	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
Q4367	Amniocore sl, per square centimeter	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
Q5101	Injection, filgrastim-sndz, biosimilar, (zarxio), 1 microgram	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity including prior treatments.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
Q5103	Injection, infliximab-dyyb, biosimilar, (inflectra), 10 mg	Prior Authorization Required	Medical necessity including site of service	This drug requires review for site of service administration in addition to review for prior authorization/medical necessity. Submit history and physical and recent lab work.
Q5104	Injection, infliximab-abda, biosimilar, (renflexis), 10 mg	Prior Authorization Required	Medical necessity including site of service	This drug requires review for site of service administration in addition to review for prior authorization/medical necessity. Submit history and physical and recent lab work.
Q5105	Injection, Epoetin Alfa-EPBX, Biosimilar, (Retacrit) (for ESRD on dialysis), 100 units	Prior Authorization Required	Medical Necessity	Submit chart notes from the ordering physician including history and physical with Hgb level and transferrin saturation or ferritin level within 1 month of initiating ESA and monthly.
Q5106	Injection, Epoetin Alfa-EPBX, Biosimilar, (Retacrit) (for non-ESRD use), 1000 units	Prior Authorization Required	Medical Necessity	Submit chart notes from the ordering physician including history and physical with Hgb level and transferrin saturation or ferritin level within 1 month of initiating ESA and monthly.
Q5107	Injection, bevacizumab-awwb, biosimilar, (mvasi), 10 mg	Prior Authorization Required	Medical Necessity	Submit History and Physical, medical necessity documentation.
Q5108	Injection, pegfilgrastim-jmdb (fulphila), biosimilar,0.5 mg	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity including prior treatments.
Q5111	Injection, pegfilgrastim-cbqv (Udenyca), biosimilar, 0.5 mg	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity including prior treatments.
Q5112	Injection, trastuzumab-dttb, biosimilar, (Ontruzant), 10 mg	Prior Authorization Required	Medical Necessity	History and physical demonstrating reason for requested medication, and lab work demonstrating HER-2/neu over expression. Please do not include infusion records.

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Q5113	Injection, trastuzumab-pkrb, biosimilar, (Herzuma), 10 mg	Prior Authorization Required	Medical Necessity	History and physical demonstrating reason for requested medication, and lab work demonstrating HER-2/neu over expression. Please do not include infusion records.
Q5114	Injection, Trastuzumab-dkst, biosimilar, (Ogivri), 10 mg	Prior Authorization Required	Medical Necessity	History and physical demonstrating reason for requested medication, and lab work demonstrating HER-2/neu over expression. Please do not include infusion records.
Q5115	Injection, rituximab-abbs, biosimilar, (Truxima), 10 mg	Prior Authorization Required	Medical necessity including site of service	This drug requires review for site of service administration in addition to review for prior authorization/medical necessity. Submit history and physical and recent lab work.
Q5116	Injection, trastuzumab-qyyp, biosimilar, (Trazimera), 10 mg	Prior Authorization Required	Medical Necessity	History and physical demonstrating reason for requested medication, and lab work demonstrating HER-2/neu over expression. Please do not include infusion records.
Q5117	Injection, trastuzumab-anns, biosimilar, (Kanjinti), 10 mg	Prior Authorization Required	Medical Necessity	History and physical demonstrating reason for requested medication, and lab work demonstrating HER-2/neu over expression. Please do not include infusion records.
Q5118	Injection, bevacizumab-bvcr, biosimilar, (Zirabev), 10 mg	Prior Authorization Required	Medical Necessity	Submit History and Physical, medical necessity documentation.
Q5119	Injection, rituximab-pvvr, biosimilar, (RUXIENCE), 10 mg	Prior Authorization Required	Medical necessity including site of service	This drug requires review for site of service administration in addition to review for prior authorization/medical necessity. Submit history and physical and recent lab work.

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Q5120	Injection, pegfilgrastim-bmez (ZIEXTENZO), biosimilar, 0.5 mg	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity including prior treatments.
Q5121	Injection, infliximab-axxq, biosimilar, (AVSOLA), 10 mg	Prior Authorization Required	Medical necessity including site of service	Submit recent history and physical, plan of care, and documentation of medical necessity including for site of service.
Q5122	Injection, pegfilgrastim-apgf (nyvepria), biosimilar, 0.5 mg	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity including prior treatments.
Q5123	Injection, rituximab-arrx, biosimilar, (Riabni), 10 mg	Prior Authorization Required	Medical necessity including site of service	Submit recent history and physical, plan of care, and documentation of medical necessity including for site of service.
Q5124	Injection, ranibizumab-nuna, biosimilar, (byooviz), 0.1 mg	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
Q5125	Injection, filgrastim-ayow, biosimilar, (Releuko), 1 mcg	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
Q5126	Injection, bevacizumab-maly, biosimilar, (Alymsys), 10 mg	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
Q5127	Injection, Pegfilgrastim-fpgk (Stimufend), biosimilar, 0.5 mg	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity including prior treatments.
Q5128	Injection, Ranibizumab-eqrn (Cimerli), biosimilar, 0.1 mg	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
Q5129	Injection, Bevacizumab-adcd (Vegzelma), biosimilar, 10 mg	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
Q5130	Injection, Pegfilgrastim-pbbk (Fylnetra), biosimilar, 0.5 mg	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity including prior treatments.
Q5133	Injection, tocilizumab-bavi (tofidence), biosimilar, 1 mg	Prior Authorization Required	Medical necessity including site of service	Submit recent history and physical, plan of care, and documentation of medical necessity including for site of service.

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Q5134	Injection, natalizumab-sztn (tyruko), biosimilar, 1 mg	Prior Authorization Required	Medical necessity including site of service	Submit recent history and physical, plan of care, and documentation of medical necessity including for site of service.
Q5135	Injection, tocilizumab-aazg (tyenne), biosimilar, 1 mg	Prior Authorization Required	Medical necessity including site of service	Submit recent history and physical, plan of care, and documentation of medical necessity including for site of service.
Q5140	Injection, adalimumab-fkjp, biosimilar, 1 mg	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
Q5141	Injection, adalimumab-aaty, biosimilar, 1 mg	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
Q5142	Injection, adalimumab-ryvk biosimilar, 1 mg	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
Q5143	Injection, adalimumab-adbm, biosimilar, 1 mg	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
Q5144	Injection, adalimumab-aacf (idacio), biosimilar, 1 mg	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
Q5145	Injection, adalimumab-afzb (abrilada), biosimilar, 1 mg	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
Q5146	Injection, trastuzumab-strf (hercessi), biosimilar, 10 mg	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
Q5147	Injection, aflibercept-ayyh (pavblu), biosimilar, 1 mg	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
Q5148	Injection, filgrastim-txid (nypozi), biosimilar, 1 microgram	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
S0013	Esketamine, nasal spray, 1 mg	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
S0128	Injection, follitropin beta, 75 IU	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
S0132	Injection, ganirelix acetate, 250 mcg	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity and procedure report.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
S0157	Becaplermin gel 0.01%, 0.5 gm	Pre-Service Review Required	Medical Necessity	History and physical demonstrating reason for requested medication, lab work if applicable, dosage and duration of treatment, office notes related to condition, medical necessity and documentation of previous therapies/treatments tried.
S0189	Testosterone pellet, 75 mg	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
S0194	Dialysis/stress vitamin supplement, oral, 100 capsules	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
S0197	Prenatal vitamins, 30-day supply	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
S0209	Wheelchair van, mileage, per mile	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
S0215	Nonemergency transportation; mileage, per mile	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
S0315	Disease management program; initial assessment and initiation of the program	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
S0316	Disease management program, follow-up/reassessment	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
S0317	Disease management program; per diem	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
S0320	Telephone calls by a registered nurse to a disease management program member for monitoring purposes; per month	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
S0510	Nonprescription lens (safety, athletic, or sunglass), per lens	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
S0596	Phakic intraocular lens for correction of refractive error	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
S0800	Laser in situ keratomileusis (LASIK)	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.

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S0810	Photorefractive keratectomy (PRK)	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
S1001	Deluxe item, patient aware (list in addition to code for basic item)	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
S1034	Artificial pancreas device system (e.g., low glucose suspend [LGS] feature) including continuous glucose monitor	Prior Authorization Required	Medical Necessity	Submit History and Physical, medical necessity documentation including prior use of insulin pump therapy
S1035	Sensor; invasive (e.g., subcutaneous), disposable, for use with artificial pancreas device system	Prior Authorization Required	Medical Necessity	Submit History and Physical, medical necessity documentation including prior use of insulin pump therapy
S1036	Transmitter; external, for use with artificial pancreas device system	Prior Authorization Required	Medical Necessity	Submit History and Physical, medical necessity documentation including prior use of insulin pump therapy
S1037	Receiver (monitor); external, for use with artificial pancreas device system	Prior Authorization Required	Medical Necessity	Submit History and Physical, medical necessity documentation including prior use of insulin pump therapy
S1040	Cranial remolding orthotic, pediatric, rigid, with soft interface material, custom fabricated, includes fitting and adjustment(s)	Prior Authorization Required	Medical Necessity	Submit letter of medical necessity documenting presence/absence of symptoms or other condition being treated
S1091	Stent, non-coronary, temporary, with delivery system (propel)	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
S2053	Transplantation of small intestine and liver allografts	Prior Authorization Required	Medical Necessity	Submit Transplant evaluation and facility acceptance letter
S2054	Transplantation of multivisceral organs	Prior Authorization Required	Medical Necessity	Submit Transplant evaluation and facility acceptance letter
S2060	Lobar lung transplantation	Prior Authorization Required	Medical Necessity	Submit Transplant evaluation and facility acceptance letter
S2065	Simultaneous pancreas kidney transplantation	Prior Authorization Required	Medical Necessity	Submit Transplant evaluation and facility acceptance letter
S2080	Laser-assisted uvulopalatoplasty (LAUP)	Prior Authorization Required	Investigative	History and physical, including sleep study results, results of CPAP trial.

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S2095	Transcatheter occlusion or embolization for tumor destruction, percutaneous, any method, using yttrium-90 microspheres	Prior Authorization Required	Medical Necessity	History and Physical, including prior treatment regimens.
S2102	Islet cell tissue transplant from pancreas; allogeneic	Prior Authorization Required	Medical Necessity	Submit Transplant evaluation and facility acceptance letter
S2107	Adoptive immunotherapy i.e. development of specific antitumor reactivity (e.g., tumor-infiltrating lymphocyte therapy) per course of treatment	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
S2112	Arthroscopy, knee, surgical for harvesting of cartilage (chondrocyte cells)	Prior Authorization Required	Medical necessity including site of service	Submit site of service, pre operative evaluation, history and physical including functional impairment, and operative report.
S2117	Arthroereisis, subtalar	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
S2142	Cord blood-derived stem-cell transplantation, allogeneic	Prior Authorization Required	Medical Necessity	Submit Transplant evaluation and facility acceptance letter
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	Prior Authorization Required	Medical Necessity	Submit Transplant evaluation and facility acceptance letter
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	Prior Authorization Required	Medical Necessity	Submit Transplant evaluation and facility acceptance letter

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S2230	Implantation of magnetic component of semi-implantavle hearing device on ossicles in middle ear	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
S2235	implantation of auditory brain stem implant	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity and procedure report.
S2300	Arthroscopy, shoulder, surgical; with thermally-induced capsulorrhaphy	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
S2340	Chemodenervation of abductor muscle(s) of vocal cord	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
S2341	Chemodenervation of adductor muscle(s) of vocal cord	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
S3005	Performance measurement, evaluation of patient self assessment, depression	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
S3800	Genetic testing for amyotrophic lateral sclerosis (ALS)	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
S3840	DNA analysis for germline mutations of the RET proto-oncogene for susceptibility to multiple endocrine neoplasia type 2	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. WA PLAN MEMBERS ONLY: No prior authorization required for requests related to stage 3 or 4 cancer; or remittent, recurrent, relapsed, or metastatic cancers. Post-service review may be required through Carelon.
S3841	Genetic testing for retinoblastoma	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.

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S3842	Genetic testing for von Hippel-Lindeau disease	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
S3844	DNA analysis of the connection 26 gene (GJB2) for susceptibility to congenital, profound deafness DNA analysis deafness	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
S3845	Genetic testing for alpha-thalassemia	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
S3846	Genetic testing for hemoglobin E beta-thalassemia	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
S3849	Genetic testing for Niemann-Pick disease	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
S3850	Genetic testing for sickle cell anemia	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
S3852	DNA analysis for APOE essilon 4 allele for susceptibility to Alzheimer's disease	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
S3853	Genetic testing for myotonic muscular dystrophy	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
S3854	Gene expression profiling panel for use in the management of breast cancer treatment	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. WA PLAN MEMBERS ONLY: No prior authorization required for requests related to stage 3 or 4 cancer; or remittent, recurrent, relapsed, or metastatic cancers. Post-service review may be required through Carelon.
S3861	Genetic testing, sodium channel, voltage-gated, type V, alpha subunit (SCN5A) and variants for suspected Brugada Syndrome	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
S3865	Comprehensive gene sequence analysis for hypertrophic cardiomyopathy	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
S3866	Genetic analysis for a specific gene mutation for hypertrophic cardiomyopathy (HCM) in an individual with a known HCM mutation in the family	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
S3870	Comparative genomic hybrization (CGH) microarray testing for developmental delay, autism spectrum disorder and/or mental retardation	Prior Authorization Required	Genetic Testing	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
S3900	Surface electromyography (EMG)	Pre-Service Review Required	Investigative	Submit history and physical, documentation of medical necessity and procedure report.
S4991	Nicotine patches, nonlegend	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
S5100	Day care services, adult; per 15 minutes	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
S5101	Day care services, adult; per half day	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
S5102	Day care services, adult; per diem	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
S5105	Day care services, center-based; services not included in program fee, per diem	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
S5108	Home care training to home care client, 15 min	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
S5109	Home care training to home care client, per session	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
S5110	Home care training, family; per 15 minutes	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
S5111	Home care training, family; per session	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
S5115	Home care training, nonfamily; per 15 minutes	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
S5116	Home care training, nonfamily; per session	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
S5120	Chore services; per 15 minutes	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
S5121	Chore services; per diem	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
S5125	Attendant care services; per 15 minutes	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
S5126	Attendant care services; per diem	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
S5130	Homemaker service, NOS; per 15 minutes	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
S5131	Homemaker service, NOS; per diem	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
S5135	Companion care, adult (e.g., IADL/ADL); per 15 minutes	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
S5136	Companion care, adult (e.g., IADL/ADL); per diem	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
S5140	Foster care, adult; per diem	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
S5141	Foster care, adult; per month	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
S5145	Foster care, therapeutic, child; per diem	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
S5146	Foster care, therapeutic, child; per month	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
S5150	Unskilled respite care, not hospice; per 15 minutes	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
S5151	Unskilled respite care, not hospice; per diem	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
S5160	Emergency response system; installation and testing	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
S5161	Emergency response system; service fee, per month (excludes installation and testing)	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
S5162	Emergency response system; purchase only	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.

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S5165	Home modifications; per service	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
S5170	Home delivered meals, including preparation; per meal	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
S5175	Laundry service, external, professional; per order	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
S5181	Unlisted home health respiratory therapy, nos, per diem	Medical necessity review will be performed upon claims submission with supporting documentation.	Medical Necessity	Review required at claims submission; submit description of procedure with supporting documentation (including operative report if surgical) only for the date of service performed.
S5185	Medication reminder service, nonface-to-face; per month	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
S5199	Personal care item, NOS, each	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
S8030	Scleral application of tantalum ring(s) for localization of lesions for proton beam therapy	Prior Authorization Required	Radiation Oncology	No review for non-cancer diagnoses. FOR CANCER DIAGNOSES ONLY: Submit online review with Carelon at www.providerportal.com. For prior authorization include history and physical, results of previous diagnostics procedure report.
S8092	Electron beam computed tomography (also known as ultrafast CT, cine CT)	Prior Authorization Required	Advanced Imaging	Submit online review with Carelon at www.providerportal.com. For Prior Authorization: History and Physical, results of previous diagnostics procedure report.
S8130	Interferential current stimulator, 2 channel	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
S8131	Interferential current stimulator, 4 channel	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
S8270	Enuresis alarm, using auditory buzzer and/or vibration device	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.

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S8460	Camisole, postmastectomy	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
S8930	Electrical stimulation of auricular acupuncture points; each 15' of personal one-on-one contact with the patient	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
S8940	Equestrian/hippotherapy, per session	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
S8948	Application of a modality (requiring constant provider attendance) to one or more areas; low-level laser; each 15 minutes	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
S8990	Physical or manipulative therapy performed for maintenance rather than restoration	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
S9002	Intra-vaginal motion sensor system, provides biofeedback for pelvic floor muscle rehabilitation device	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
S9055	Procuren or other growth factor preparation to promote wound healing	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
S9090	Vertebral axial decompression, per session	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
S9117	Back school, per visit	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
S9123	Nursing care, in the home; by registered nurse, per hour	Prior Authorization Required	Medical Necessity	Notes documenting medical necessity, each date of service, and homebound status. Include plan of care
S9124	Nursing care, in the home; by licensed practical nurse, per hour	Prior Authorization Required	Medical Necessity	Chart notes for each home visit and therapy notes for each discipline providing treatment
S9432	Medical foods for noninborn errors of metabolism	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
S9433	Medical food nutritionally complete, administered orally, providing 100% of nutritional intake	Prior Authorization Required	Medical Necessity	History and Physical, documentation of medical necessity.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
S9434	Modified solid food supplements for inborn errors of metabolism	Retrospective Review	Medical Necessity (only when delivered orally)	Only covered when delivered by feeding tube or (if oral) for diagnosis that are considered medically necessary.
S9435	Medical foods for inborn errors of metabolism	Retrospective Review	Medical Necessity (only when delivered orally)	Only covered when delivered by feeding tube or (if oral) for diagnosis that are considered medically necessary.
S9445	Patient education, not otherwise classified, nonphysician provider, individual, per session	Medical necessity review will be performed upon claims submission with supporting documentation.	Medical Necessity	Review required at claims submission; submit description of procedure with supporting documentation (including operative report if surgical) only for the date of service performed.
S9446	Patient education, not otherwise classified, nonphysician provider, group, per session	Medical necessity review will be performed upon claims submission with supporting documentation.	Medical Necessity	Review required at claims submission; submit description of procedure with supporting documentation (including operative report if surgical) only for the date of service performed.
S9542	Home injectable therapy, not otherwise classified, (drugs and nursing visits coded separately), per diem	Medical necessity review will be performed upon claims submission with supporting documentation.	Medical Necessity	Review required at claims submission; submit description of procedure with supporting documentation (including operative report if surgical) only for the date of service performed.
S9810	Home therapy; professional pharmacy services for provision of infusion, specialty drug administration, and/or disease state management, not otherwise classified, per hour (do not use this code with any per diem code)	Medical necessity review will be performed upon claims submission with supporting documentation.	Medical Necessity	Review required at claims submission; submit description of procedure with supporting documentation (including operative report if surgical) only for the date of service performed.
S9900	Services by authorized Christian Science practitioner for the process of healing, per diem; not to be used for rest or study; excludes in-patient services	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
S9960	Ambulance service, conventional air services, nonemergency transport, one way (fixed wing)	Prior Authorization Required	Medical Necessity	Submit progress notes for last 24 hours prior to transport, physician order including medical records supporting rationale for transport
S9961	Ambulance service, conventional air service, nonemergency transport, one way (rotary wing)	Prior Authorization Required	Medical Necessity	Submit progress notes for last 24 hours prior to transport, physician order including medical records supporting rationale for transport
S9970	Health club membership, annual	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
S9976	Lodging, per diem, not otherwise classified	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
S9977	Meals, per diem, not otherwise specified	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
S9986	Not medically necessary service (patient is aware that service not medically necessary)	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
S9988	Services provided as part of a phase I clinical trial	Prior Authorization Required	Medical Necessity	Submit History and Physical, clinical trial information and medical necessity documentation per medical policy 10.01.518 Clinical Trials.
S9990	Services provided as part of a Phase II clinical trial	Prior Authorization Required	Medical Necessity	Submit History and Physical, clinical trial information and medical necessity documentation per medical policy 10.01.518 Clinical Trials.
S9991	Services provided as part of a phase III clinical trial	Prior Authorization Required	Medical Necessity	Submit History and Physical, clinical trial information and medical necessity documentation per medical policy 10.01.518 Clinical Trials.
S9992	Transportation costs to and from trial location and local transportation costs (e.g., fares for taxicab or bus) for clinical trial participant and one caregiver/companion	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.

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S9994	Lodging costs (e.g., hotel charges) for clinical trial participant and one caregiver/companion	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
S9996	Meals for clinical trial participant and one caregiver/companion	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
T1000	Private duty/independent nursing service(s), licensed, up to 15 minutes	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
T1002	RN services, up to 15 minutes	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
T1003	LPN/LVN services, up to 15 minutes	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
T1004	Services of a qualified nursing aide, up to 15 minutes	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
T1005	Respite care services, up to 15 minutes	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
T1009	Child sitting services for children of the individual receiving alcohol and/or substance abuse services	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
T1010	Meals for individuals receiving alcohol and/or substance abuse services (when meals not included in the program)	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
T1013	Sign language or oral interpretive services, per 15 minutes	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
T1015	Clinic visit/encounter, all-inclusive	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
T1016	Case management, each 15 minutes	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
T1017	Targeted case management, each 15 minutes	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
T1018	School-based individualized education program (IEP) services, bundled	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
T1019	Personal care services, per 15 minutes, not for an inpatient or resident of a hospital, nursing facility, ICF/MR or IMD, part of the individualized plan of treatment (code may not be used to identify services provided by home health aide or certified nurse assistant)	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
T1020	Personal care services, per diem, not for an inpatient or resident of a hospital, nursing facility, ICF/MR or IMD, part of the individualized plan of treatment (code may not be used to identify services provided by home health aide or certified nurse assistant)	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
T1021	Home health aide or certified nurse assistant, per visit	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
T1022	Contracted home health agency services, all services provided under contract, per day	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
T1023	Screening to determine the appropriateness of consideration of an individual for participation in a specified program, project or treatment protocol, per encounter	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
T1027	Family training and counseling for child development, per 15 minutes	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
T1028	Assessment of home, physical and family environment, to determine suitability to meet patient's medical needs	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
T1029	Comprehensive environmental lead investigation, not including laboratory analysis, per dwelling	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
T1032	Services performed by a doula birth worker, per 15 minutes	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
T1033	Services performed by a doula birth worker, per diem	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
T1040	Medicaid certified community behavioral health clinic services, per diem	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
T1041	Medicaid certified community behavioral health clinic services, per month	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
T1999	Miscellaneous therapeutic items and supplies, retail purchases, not otherwise classified; identify product in "remarks"	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
T2001	Nonemergency transportation; patient attendant/escort	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
T2002	Nonemergency transportation; per diem	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
T2003	Nonemergency transportation; encounter/trip	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
T2004	Nonemergency transport; commercial carrier, multipass	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
T2005	Nonemergency transportation; stretcher van	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
T2007	Transportation waiting time, air ambulance and nonemergency vehicle, one-half (1/2) hour increments	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
T2012	Habilitation, educational; waiver, per diem	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
T2013	Habilitation, educational, waiver; per hour	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
T2014	Habilitation, prevocational, waiver; per diem	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
T2015	Habilitation, prevocational, waiver; per hour	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
T2016	Habilitation, residential, waiver; per diem	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.

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T2017	Habilitation, residential, waiver; 15 minutes	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
T2018	Habilitation, supported employment, waiver; per diem	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
T2019	Habilitation, supported employment, waiver; per 15 minutes	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
T2020	Day habilitation, waiver; per diem	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
T2021	Day habilitation, waiver; per 15 minutes	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
T2022	Case management, per month	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
T2023	Targeted case management; per month	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
T2024	Service assessment/plan of care development, waiver	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
T2025	Waiver services; not otherwise specified (NOS)	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
T2026	Specialized childcare, waiver; per diem	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
T2027	Specialized childcare, waiver; per 15 minutes	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
T2028	Specialized supply, not otherwise specified, waiver	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
T2029	Specialized medical equipment, not otherwise specified, waiver	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
T2030	Assisted living, waiver; per month	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
T2031	Assisted living; waiver, per diem	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
T2032	Residential care, not otherwise specified (NOS), waiver; per month	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
T2033	Residential care, not otherwise specified (NOS), waiver; per diem	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.

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T2034	Crisis intervention, waiver; per diem	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
T2035	Utility services to support medical equipment and assistive technology/devices, waiver	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
T2036	Therapeutic camping, overnight, waiver; each session	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity and procedure report.
T2037	Therapeutic camping, day, waiver; each session	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity and procedure report.
T2038	Community transition, waiver; per service	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
T2039	Vehicle modifications, waiver; per service	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
T2040	Financial management, self-directed, waiver; per 15 minutes	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
T2041	Supports brokerage, self-directed, waiver; per 15 minutes	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
T2047	Habilitation, prevocational, waiver; per 15 minutes	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
T2049	Nonemergency transportation; stretcher van, mileage; per mile	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
T2050	Financial management, self-directed, waiver; per diem	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
T2051	Supports brokerage, self-directed, waiver; per diem	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
T4521	Adult sized disposable incontinence product, brief/diaper, small, each	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
T4522	Adult sized disposable incontinence product, brief/diaper, medium, each	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
T4523	Adult sized disposable incontinence product, brief/diaper, large, each	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
T4524	Adult sized disposable incontinence product, brief/diaper, extra large, each	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
T4525	Adult sized disposable incontinence product, protective underwear/pull-on, small size, each	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
T4526	Adult sized disposable incontinence product, protective underwear/pull-on, medium size, each	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
T4527	Adult sized disposable incontinence product, protective underwear/pull-on, large size, each	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
T4528	Adult sized disposable incontinence product, protective underwear/pull-on, extra large size, each	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
T4529	Pediatric sized disposable incontinence product, brief/diaper, small/medium size, each	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
T4530	Pediatric sized disposable incontinence product, brief/diaper, large size, each	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
T4531	Pediatric sized disposable incontinence product, protective underwear/pull-on, small/medium size, each	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
T4532	Pediatric sized disposable incontinence product, protective underwear/pull-on, large size, each	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
T4533	Youth sized disposable incontinence product, brief/diaper, each	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
T4534	Youth sized disposable incontinence product, protective underwear/pull-on, each	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
T4535	Disposable liner/shield/guard/pad/undergarment, for incontinence, each	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.

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T4536	Incontinence product, protective underwear/pull-on, reusable, any size, each	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
T4537	Incontinence product, protective underpad, reusable, bed size, each	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
T4538	Diaper service, reusable diaper, each diaper	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
T4539	Incontinence product, diaper/brief, reusable, any size, each	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
T4540	Incontinence product, protective underpad, reusable, chair size, each	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
T4541	Incontinence product, disposable underpad, large, each	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
T4542	Incontinence product, disposable underpad, small size, each	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
T4543	Disposable incontinence product, brief/diaper, bariatric, each	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
T4545	Incontinence product, disposable, penile wrap, each	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
T5001	Positioning seat for persons with special orthopedic needs	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
T5999	Supply, not otherwise specified	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
V2526	Contact lens, hydrophilic, with blue-violet filter, per lens	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
V2615	Telescopic and other compound lens system, including distance vision telescopic, near vision telescopes and compound microscopic lens system	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
V2756	Eye glass case	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
V2787	Astigmatism correcting function of intraocular lens	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.

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V2788	Presbyopia correcting function of intraocular lens	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
V5095	Semi-implantable middle ear hearing prosthesis	Possible Denial; Medical Records Optional	Investigative	Documentation optional.
V5269	Assistive listening device, alerting, any type	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
V5270	Assistive listening device, television amplifier, any type	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
V5271	Assistive listening device, television caption decoder	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
V5272	Assistive listening device, TDD	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
V5273	Assistive listening device, for use with cochlear implant	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.
V5274	Assistive listening device, not otherwise specified	Non-covered Service	Benefit Exception	Considered non-covered unless member's contract indicates coverage.