BlueCross. BlueShield.
Federal Employee Program.

FEP Blue Focus Plan only
Code List
(Codes reviewed are subject to change)

How do I ensure accurate coverage information?
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.

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., Advanced Benefit Determination (ABD), 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 Advanced Benefit Determination (ABD). 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 ABD.

- **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.
- **Advanced Benefit Determination:** This is a utilization management review. ABD reviews are not contractually required; however, if an ABD review for medical necessity is not obtained, we will conduct a retrospective medical necessity review. If a provider performs a service or procedure without an ABD review, the member or provider may have to pay the full-service cost.

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.

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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	Medical Necessity	History and physical, and chart notes from ordering provider with reason for testing
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	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, and clinical documentation to support testing
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	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, and clinical documentation to support testing
0004M	Scoliosis, DNA analysis of 53 single nucleotide polymorphisms (SNPs), using saliva, prognostic algorithm reported as a risk score	Prior Authorization Required	Medical Necessity	History and physical, and chart notes from ordering provider with reason for testing
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	Investigative	History and physical, and chart notes from ordering provider with reason for testing
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	Medical Necessity	History and physical, and chart notes from ordering provider with reason for testing

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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	Medical Necessity	History and physical, and chart notes from ordering provider with reason for testing
0007U	Drug test(s), presumptive, with definitive confirmation of positive results, any number of drug classes, urine, includes specimen verification including DNA authentication in comparison to buccal DNA, per date of service	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, and clinical documentation to support testing
0008U	Helicobacter pylori detection and antibiotic resistance, DNA, 16S and 23S rRNA, gyrA, pbp1, rdxA and rpoB, next-generation sequencing, formalin-fixed paraffin-embedded or fresh tissue or fecal sample, predictive, reported as positive or negative for resistance to clarithromycin, fluoroquinolones, metronidazole, amoxicillin, tetracycline, and rifabutin	Prior Authorization Required	Medical Necessity	History and physical, and chart notes from ordering provider with reason for testing
0009U	Oncology (breast cancer), ERBB2 (HER2) copy number by FISH, tumor cells from formalin fixed paraffin embedded tissue isolated using image-based dielectrophoresis (DEP) sorting, reported as ERBB2 gene amplified or non-amplified	Prior Authorization Required	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
00103	Anesthesia for reconstructive procedures of eyelid (eg, blepharoplasty, ptosis surgery)	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, documentation of medical necessity, and photographs
0010U	Infectious disease (bacterial), strain typing by whole genome sequencing, phylogenetic-based report of strain relatedness, per submitted isolate	Prior Authorization Required	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing

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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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
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	Medical Necessity	History and physical, and chart notes from ordering provider with reason for testing
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	Medical Necessity	History and physical, and chart notes from ordering provider with reason for testing
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)	Prior Authorization Required	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
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	Medical Necessity	History and physical, and chart notes from ordering provider with reason for testing

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00170	Anesthesia for intraoral procedures, including biopsy; not otherwise specified	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, documentation of medical necessity, and operative report. NOTE:Dental covers for dental procedures; all others refer to medical review
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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
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	Medical Necessity	History and physical, and chart notes from ordering provider with reason for testing
0018M	Transplantation medicine (allograft rejection, renal), measurement of donor and third-party-induced CD154+T-cytotoxic memory cells, utilizing whole peripheral blood, algorithm reported as a rejection risk score	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history and physical, documentation of medical necessity.
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	Medical Necessity	History and physical, and chart notes from ordering provider with reason for testing
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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing

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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	Medical Necessity	History and physical, and chart notes from ordering provider with reason for testing
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	Medical Necessity	History and physical, and chart notes from ordering provider with reason for testing
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	Investigative	History and physical, and chart notes from ordering provider with reason for testing
0027U	JAK2 (Janus kinase 2) (eg, myeloproliferative disorder) gene analysis, targeted sequence analysis exons 12-15	Prior Authorization Required	Medical Necessity	History and physical, and chart notes from ordering provider with reason for testing
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	Medical Necessity	History and physical, and chart notes from ordering provider with reason for testing
0030U	Drug metabolism (warfarin drug response), targeted sequence analysis (ie, CYP2C9, CYP4F2, VKORC1, rs12777823)	Prior Authorization Required	Investigative	History and physical, and chart notes from ordering provider with reason for testing

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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	Medical Necessity	History and physical, and chart notes from ordering provider with reason for testing
0032U	COMT (catechol-O-methyltransferase)(drug metabolism) gene analysis, c.472G>A (rs4680) variant	Prior Authorization Required	Investigative	History and physical, and chart notes from ordering provider with reason for testing
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	Investigative	History and physical, and chart notes from ordering provider with reason for testing
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	Medical Necessity	History and physical, and chart notes from ordering provider with reason for testing
0036U	Exome (ie, somatic mutations), paired formalin-fixed paraffin-embedded tumor tissue and normal specimen, sequence analyses	Prior Authorization Required	Medical Necessity	History and physical, and chart notes from ordering provider with reason for testing
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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
0039U	Deoxyribonucleic acid (DNA) antibody, double stranded, high avidity	Prior Authorization Required	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing

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0040U	BCR/ABL1 (t(9;22)) (eg, chronic myelogenous leukemia) translocation analysis, major breakpoint, quantitative	Prior Authorization Required	Medical Necessity	History and physical, and chart notes from ordering provider with reason for testing
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	Medical Necessity	Submit history and physical and documentation of medical necessity, and procedure/imaging 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)	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
0046U	FLT3 (fms-related tyrosine kinase 3) (eg, acute myeloid leukemia) internal tandem duplication (ITD) variants, quantitative	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
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	Advance Benefit Determination (ABD) recommended	Investigative	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
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	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
0049U	NPM1 (nucleophosmin) (eg, acute myeloid leukemia) gene analysis, quantitative	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing

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0050U	Targeted genomic sequence analysis panel, acute myelogenous leukemia, DNA analysis, 194 genes, interrogation for sequence variants or rearrangements	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
0054T	Computer-assisted musculoskeletal surgical navigational orthopedic procedure, with image-guidance based on fluoroscopic images (List separately in addition to code for primary procedure)	Prior Authorization Required	Investigative	Submit procedure/testing report
0055T	Computer-assisted musculoskeletal surgical navigational orthopedic procedure, with image-guidance based on CT/MRI images (List separately in addition to code for primary procedure)	Prior Authorization Required	Investigative	Submit procedure/testing report
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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
0067U	Oncology (breast), immunohistochemistry, protein expression profiling of 4 biomarkers (matrix metalloproteinase-1 [MMP-1], carcinoembryonic antigen-related cell adhesion molecule 6 [CEACAM6], hyaluronoglucosaminidase [HYAL1], highly expressed in cancer protein [HEC1]), formalin-fixed paraffin-embedded precancerous breast tissue, algorithm reported as carcinoma risk score	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history and physical, documentation of medical necessity.
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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing

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0070U	CYP2D6 (cytochrome P450, family 2, subfamily D, polypeptide 6) (eg, drug metabolism) gene analysis, common and select rare variants (ie, *2, *3, *4, *4N, *5, *6, *7, *8, *9, *10, *11, *12, *13, *14A, *14B, *15, *17, *29, *35, *36, *41, *57, *61, *63, *68, *83, *xN)	Prior Authorization Required	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
0071T	Focused ultrasound ablation of uterine leiomyomata, including MR guidance; total leiomyomata, volume less than 200 cc of tissue	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history and physical, documentation of medical necessity and procedure report.
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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
0072T	Focused ultrasound ablation of uterine leiomyomata, including MR guidance; total leiomyomata volume greater or equal to 200 cc of tissue	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history and physical, documentation of medical necessity and procedure report.
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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing

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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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
0075T	Transcatheter placement of extracranial vertebral artery stent(s), including radiologic supervision and interpretation, open or percutaneous; initial vessel	Advance Benefit Determination (ABD) recommended	Investigative	Submit procedure/testing 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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
0076T	Transcatheter placement of extracranial vertebral artery stent(s), including radiologic supervision and interpretation, open or percutaneous; each additional vessel	Advance Benefit Determination (ABD) recommended	Investigative	Submit procedure/testing 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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
0079U	Comparative DNA analysis using multiple selected single-nucleotide polymorphisms (SNPs), urine and buccal DNA, for specimen identity verification	Prior Authorization Required	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing

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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	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, and documentation of medical necessity, including chart notes from ordering provider with reason for testing
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	Investigative	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
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	Investigative	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
0089U	Oncology (melanoma), gene expression profiling by RTqPCR, PRAME and LINC00518, superficial collection using adhesive patch(es)	Prior Authorization Required	Investigative	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
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	Investigative	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
0091U	Oncology (colorectal) screening, cell enumeration of circulating tumor cells, utilizing whole blood, algorithm, for the presence of adenoma or cancer, reported as a positive or negative result	Prior Authorization Required	Investigative	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing

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0094U	Genome (eg, unexplained constitutional or heritable disorder or syndrome), rapid sequence analysis	Prior Authorization Required	Investigative	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
0095T	Removal of total disc arthroplasty (artificial disc), anterior approach, each additional interspace, cervical (List separately in addition to code for primary procedure)	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, plan of care, and documentation of medical necessity. medical necessity review will be performed upon claims submission with supporting documentation
0100T	Placement of a subconjunctival retinal prosthesis receiver and pulse generator, and implantation of intra-ocular retinal electrode array, with vitrectomy	Advance Benefit Determination (ABD) recommended	Investigative	Submit procedure/testing report
0101T	Extracorporeal shock wave involving musculoskeletal system, not otherwise specified; high energy	Advance Benefit Determination (ABD) recommended	Investigative	Submit procedure/testing report
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	Investigative	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
0102T	Extracorporeal shock wave, high energy, performed by a physician, requiring anesthesia other than local, involving lateral humeral epicondyle	Advance Benefit Determination (ABD) recommended	Investigative	Submit procedure/testing report

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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	Investigative	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
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	Investigative	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
0106T	Quantitative sensory testing (QST), testing and interpretation per extremity; using touch pressure stimuli to assess large diameter sensation	Advance Benefit Determination (ABD) recommended	Investigative	Submit procedure/testing report
0107T	Quantitative sensory testing (QST), testing and interpretation per extremity; using vibration stimuli to assess large diameter fiber sensation	Advance Benefit Determination (ABD) recommended	Investigative	Submit procedure/testing report
0108T	Quantitative sensory testing (QST), testing and interpretation per extremity; using cooling stimuli to assess small nerve fiber sensation and hyperalgesia	Advance Benefit Determination (ABD) recommended	Investigative	Submit procedure/testing report
0109T	Quantitative sensory testing (QST), testing and interpretation per extremity; using heat-pain stimuli to assess small nerve fiber sensation and hyperalgesia	Advance Benefit Determination (ABD) recommended	Investigative	Submit procedure/testing report

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0110T	Quantitative sensory testing (QST), testing and interpretation per extremity; using other stimuli to assess sensation	Advance Benefit Determination (ABD) recommended	Investigative	Submit procedure/testing report
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	Investigative	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
0112U	Infectious agent detection and identification, targeted sequence analysis (16S and 18S rRNA genes) with drug-resistance gene	Prior Authorization Required	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
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	Investigative	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
0114U	Gastroenterology (Barrett's esophagus), VIM and CCNA1 methylation analysis, esophageal cells, algorithm reported as likelihood for Barrett's esophagus	Prior Authorization Required	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
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	Investigative	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing

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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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing

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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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
0136U	ATM (ataxia telangiectasia mutated) (eg, ataxia telangiectasia) mRNA sequence analysis (List separately in addition to code for primary procedure)	Prior Authorization Required	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing

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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	Medical Necessity Review Required	History and physical, and clinical documentation supporting the reasoning for testing (including family history)
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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing

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0156U	Copy number (EG, intellectual disability, dysmorphology), sequence analysis	Prior Authorization Required	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing

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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	Advance Benefit Determination (ABD) recommended	Investigative	Submit history, physical, lab report and documentation of medical necessity
0164T	Removal of total disc arthroplasty, anterior approach, lumbar, each additional interspace (List separately in addition to code for primary procedure	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, documentation of medical necessity and plan of care. medical necessity review will be performed upon claims submission with supporting documentation
0165T	Revision of total disc arthroplasty (artificial disc),, anterior approach, lumbar, each additional interspace	Advance Benefit Determination (ABD) recommended	Investigative	History and physical, documentation of medical necessity, and procedure report. medical necessity review will be performed upon claims submission with supporting documentation
0169U	NUDT15 (nudix hydrolase 15) and TPMT (thiopurine S-methyltransferase) (eg, drug metabolism) gene analysis, common variants	Prior Authorization Required	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing

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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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
0173U	Psychiatry (ie, depression, anxiety), genomic analysis panel, includes variant analysis of 14 genes	Prior Authorization Required	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
0174T	Computer-aided detection (CAD) (computer algorithm analysis of digital image data for lesion detection) with further physician review for interpretation and report, with or without digitization of film radiographic images, chest radiograph(s), performed c	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history and physical, documentation of medical necessity.
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	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical and documentation supporting reasoning for testing

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0175T	Computer-aided detection (CAD) (computer algorithm analysis of digital image data for lesion detection) with further physician review for interpretation and report, with or without digitization of film radiographic images, chest radiograph(s), performed r	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history and physical, documentation of medical necessity.
0175U	Psychiatry (eg, depression, anxiety), genomic analysis panel, variant analysis of 15 genes	Prior Authorization Required	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
0180U	Red cell antigen (ABO blood group) genotyping (ABO), gene analysis Sanger/chain termination/conventional sequencing, ABO (ABO, alpha 1-3-N-acetylgalactosaminyltransferase and alpha 1-3-galactosyltransferase) gene, including subtyping, 7 exons	Prior Authorization Required	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
0181U	Red cell antigen (Colton blood group) genotyping (CO), gene analysis, AQP1 (aquaporin 1 [Colton blood group]) exon 1	Prior Authorization Required	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing

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0182U	Red cell antigen (Cromer blood group) genotyping (CROM), gene analysis, CD55 (CD55 molecule [Cromer blood group]) exons 1-10	Prior Authorization Required	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
0183U	Red cell antigen (Diego blood group) genotyping (DI), gene analysis, SLC4A1 (solute carrier family 4 member 1 [Diego blood group]) exon 19	Prior Authorization Required	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
0184T	Excision of rectal tumor, transanal endoscopic microsurgical approach (ie, TEMS), including muscularis propria (ie, full thickness)	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
0184U	Red cell antigen (Dombrock blood group) genotyping (DO), gene analysis, ART4 (ADP-ribosyltransferase 4 [Dombrock blood group]) exon 2	Prior Authorization Required	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
0185U	Red cell antigen (H blood group) genotyping (FUT1), gene analysis, FUT1 (fucosyltransferase 1 [H blood group]) exon 4	Prior Authorization Required	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
0186U	Red cell antigen (H blood group) genotyping (FUT2), gene analysis, FUT2 (fucosyltransferase 2) exon 2	Prior Authorization Required	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
0187U	Red cell antigen (Duffy blood group) genotyping (FY), gene analysis, ACKR1 (atypical chemokine receptor 1 [Duffy blood group]) exons 1-2	Prior Authorization Required	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
0188U	Red cell antigen (Gerbich blood group) genotyping (GE), gene analysis, GYPC (glycophorin C [Gerbich blood group]) exons 1-4	Prior Authorization Required	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
0189U	Red cell antigen (MNS blood group) genotyping (GYPA), gene analysis, GYPA (glycophorin A [MNS blood group]) introns 1, 5, exon 2	Prior Authorization Required	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing

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0190U	Red cell antigen (MNS blood group) genotyping (GYPB), gene analysis, GYPB (glycophorin B [MNS blood group]) introns 1, 5, pseudoexon 3	Prior Authorization Required	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
0191U	Red cell antigen (Indian blood group) genotyping (IN), gene analysis, CD44 (CD44 molecule [Indian blood group]) exons 2, 3, 6	Prior Authorization Required	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
0192U	Red cell antigen (Kidd blood group) genotyping (JK), gene analysis, SLC14A1 (solute carrier family 14 member 1 [Kidd blood group]) gene promoter, exon 9	Prior Authorization Required	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
0193U	Red cell antigen (JR blood group) genotyping (JR), gene analysis, ABCG2 (ATP binding cassette subfamily G member 2 [Junior blood group]) exons 2-26	Prior Authorization Required	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
0194U	Red cell antigen (Kell blood group) genotyping (KEL), gene analysis, KEL (Kell metallo-endopeptidase [Kell blood group]) exon 8	Prior Authorization Required	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
0195U	KLF1 (Kruppel-like factor 1), targeted sequencing (ie, exon 13)	Prior Authorization Required	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
0195U	KLF1 (Kruppel-like factor 1), targeted sequencing (ie, exon 13)	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
01966	Anesthesia for induced abortion procedures	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
0196U	Red cell antigen (Lutheran blood group) genotyping (LU), gene analysis, BCAM (basal cell adhesion molecule [Lutheran blood group]) exon 3	Prior Authorization Required	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing

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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	Prior Authorization Required	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
0198T	Measurement of ocular blood flow by repetitive intraocular pressure sampling, with interpretation and report	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history and physical, documentation of medical necessity.
0198U	Red cell antigen (RH blood group) genotyping (RHD and RHCE), gene analysis Sanger/chain termination/conventional sequencing, RHD (Rh blood group D antigen) exons 1-10 and RHCE (Rh blood group CcEe antigens) exon 5	Prior Authorization Required	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
01999	Unlisted anesthesia procedure(s)	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and phsyical, procedure/operative report, and documentation to describe services
0199U	Red cell antigen (Scianna blood group) genotyping (SC), gene analysis, ERMAP (erythroblast membrane associated protein [Scianna blood group]) exons 4, 12	Prior Authorization Required	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
0200U	Red cell antigen (Kx blood group) genotyping (XK), gene analysis, XK (X-linked Kx blood group) exons 1-3	Prior Authorization Required	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
0201U	Red cell antigen (Yt blood group) genotyping (YT), gene analysis, ACHE (acetylcholinesterase [Cartwright blood group]) exon 2	Prior Authorization Required	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing

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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	Advance Benefit Determination (ABD) recommended	Investigative	History and physical, documentation of medical necessity, and operative 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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
0207T	Evacuation of meibomian glands, automated, using heat and intermittent pressure, unilateral	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
0208T	Pure tone audiometry (threshold), automated; air only	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history and physical, documentation of medical necessity.
0209T	Pure tone audiometry (threshold), automated; air and bone	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history and physical, documentation of medical necessity.
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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
0210T	Speech audiometry threshold, automated	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history and physical, documentation of medical necessity.

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0211T	Speech audiometry threshold, automated; with speech recognition	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history and physical, documentation of medical necessity.
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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
0212T	Comprehensive audiometry threshold evaluation and speech recognition (0209T, 0211T combined), automated	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history and physical, documentation of medical necessity.
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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing

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0214U	Rare diseases (constitutional/heritable disorders), whole exome and mitochondrial DNA sequence analysis, including small sequence changes, deletions, duplications, short tandem repeat gene expansions, and variants in non-uniquely mappable regions, blood or saliva, identification and categorization of genetic variants, proband	Prior Authorization Required	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing

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0218U	Neurology (muscular dystrophy), DMD gene sequence analysis, including small sequence changes, deletions, duplications, and variants in non-uniquely mappable regions, blood or saliva, identification and characterization of genetic variants	Prior Authorization Required	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
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	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history and physical, documentation of medical necessity.
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	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history and physical, documentation of medical necessity.
0220U	Oncology (breast cancer), image analysis with artificial intelligence assessment of 12 histologic and immunohistochemical features, reported as a recurrence score	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history and physical, documentation of medical necessity and procedure report.
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	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history and physical, documentation of medical necessity.
0221U	Red cell antigen (ABO blood group) genotyping (ABO), gene analysis, next-generation sequencing, ABO (ABO, alpha 1-3-N-acetylgalactosaminyltransferase and alpha 1-3-galactosyltransferase) gene	Prior Authorization Required	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing

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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)	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history and physical, documentation of medical necessity.
0229U	BCAT1 (Branched chain amino acid transaminase 1) or IKZF1 (IKAROS family zinc finger 1) (eg, colorectal cancer) promoter methylation analysis	Prior Authorization Required	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
0232T	Injection(s), platelet rich plasma, any tissue, including image guidance, harvesting and preparation when performed	Advance Benefit Determination (ABD) recommended	Investigative	Submit procedure/testing report

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing

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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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
0238T	Transluminal peripheral atherectomy, open or percutaneous, including radiological supervision and interpretation; iliac artery, each vessel	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, pre-operative evaluation(s), imaging reports, conservative measures and response, operative/procedure report, anesthesia report and documentation of medical necessity
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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
0243U	Obstetrics (preeclampsia), biochemical assay of placental-growth factor, time-resolved fluorescence immunoassay, maternal serum, predictive algorithm reported as a risk score for preeclampsia	Advance Benefit Determination (ABD) recommended	Investigative	Submit history and physical, documentation of medical necessity and procedure report.
0244U	Oncology DNA, comprehensive genomic profiling, 257 genes, interrogation for single-nucleotide variants, insertions/deletions, copy number alterations, gene rearrangements	Prior Authorization Required	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
0247U	OBSTETRICS (PRETERM BIRTH), INSULIN-LIKE GROTH FACTOR-BINDING PROTEIN 4 (IGFBP4), SEX HORMONE-BINDING GLOBULIN (SHBG) QUANTITATIVE MEASUREMENT BY LC-MS/MS, UTILIZING MATERNAL BLOOD, COMBINED WITH CLINICAL DATA, REPORTED AS PREDICTIVE-RISK STRATIFICATION FOR SPONTANEOUS PRETERM BIRTH	Advance Benefit Determination (ABD) recommended	Investigative	Submit history and physical, documentation of medical necessity and procedure report.
0248U	Oncology, spheroid cell culture in 3D microenvironment, 12-drug panel, brain- or brain metastasis-response prediction for each drug	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history, physical, lab report and documentation of medical necessity
0249U	Oncology (breast), semiquantitative analysis of 32 phosphoproteins and protein analytes, includes laser capture microdissection, with algorithmic analysis and interpretative report	Prior Authorization Required	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing

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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)	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
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	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing

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Code List

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	Advance Benefit Determination (ABD) recommended	Investigative	Submit procedure/testing report
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	Advance Benefit Determination (ABD) recommended	Investigative	Submit procedure/testing report
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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
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	Advance Benefit Determination (ABD) recommended	Investigative	Submit procedure/testing report
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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing

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Code List

Code	Description	Plan Review Requirement	Reviewed For	Records Request
0266T	Implantation or replacement of carotid sinus baroreflex activation device; total system (includes generator placement, unilateral or bilateral lead placement, intra-operative interrogation, programming, and repositioning, when performed)	Advance Benefit Determination (ABD) recommended	Investigative	Submit procedure/testing report
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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
0267T	Implantation or replacement of carotid sinus baroreflex activation device; lead only, unilateral (includes intra-operative interrogation, programming, and repositioning, when performed)	Advance Benefit Determination (ABD) recommended	Investigative	Submit procedure/testing 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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
0268T	Implantation or replacement of carotid sinus baroreflex activation device; pulse generator only (includes intra-operative interrogation, programming, and repositioning, when performed)	Advance Benefit Determination (ABD) recommended	Investigative	Submit procedure/testing report
0268U	Hematology (atypical hemolytic uremic syndrome [aHUS]), genomic sequence analysis of 15 genes, blood, buccal swab, or amniotic fluid	Prior Authorization Required	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing

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Code List

Code	Description	Plan Review Requirement	Reviewed For	Records Request
0269T	Revision or removal of carotid sinus baroreflex activation device; total system (includes generator placement, unilateral or bilateral lead placement, intra-operative interrogation, programming, and repositioning, when performed)	Advance Benefit Determination (ABD) recommended	Investigative	Submit procedure/testing report
0269U	Hematology (autosomal dominant congenital thrombocytopenia), genomic sequence analysis of 22 genes, blood, buccal swab, or amniotic fluid	Prior Authorization Required	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
0270T	Revision or removal of carotid sinus baroreflex activation device; lead only, unilateral (includes intra-operative interrogation, programming, and repositioning, when performed)	Advance Benefit Determination (ABD) recommended	Investigative	Submit procedure/testing report
0270U	Hematology (congenital coagulation disorders), genomic sequence analysis of 20 genes, blood, buccal swab, or amniotic fluid	Prior Authorization Required	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
0271T	Revision or removal of carotid sinus baroreflex activation device; pulse generator only (includes intra-operative interrogation, programming, and repositioning, when performed)	Advance Benefit Determination (ABD) recommended	Investigative	Submit procedure/testing report
0271U	Hematology (congenital neutropenia), genomic sequence analysis of 24 genes, blood, buccal swab, or amniotic fluid	Prior Authorization Required	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
0272T	Interrogation device evaluation (in person), carotid sinus baroreflex activation system, including telemetric iterative communication with the implantable device to monitor device diagnostics and programmed therapy values, with interpretation and report	Advance Benefit Determination (ABD) recommended	Investigative	Submit procedure/testing report

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Code List

Code	Description	Plan Review Requirement	Reviewed For	Records Request
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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
0273T	Interrogation device evaluation (in person), carotid sinus baroreflex activation system, the implantable device to monitor device diagnostics and programmed therapy values, with interpretation and report; with programming	Advance Benefit Determination (ABD) recommended	Investigative	Submit procedure/testing 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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
0274T	Percutaneous laminotomy/laminectomy (interlaminar approach) for decompression of neural elements, (with or without ligamentous resection, discectomy, facetectomy and/or foraminotomy), any method, under indirect image guidance (e.g., fluoroscopic CT), single or multiple levels, unilateral or bilateral, cervical or thoracic	Advance Benefit Determination (ABD) recommended	Investigative	Submit procedure/testing report
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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing

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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	Advance Benefit Determination (ABD) recommended	Investigative	Submit procedure/testing report
0276U	Hematology (inherited thrombocytopenia), genomic sequence analysis of 42 genes, blood, buccal swab, or amniotic fluid	Prior Authorization Required	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
0278T	Transcutaneous electrical modulation pain reprocessing (eg, scrambler therapy), each treatment session (includes placement of electrodes)	Advance Benefit Determination (ABD) recommended	Medical Necessity	Letter of medical necessity, and documentation supporting the need for medical equiment, functional status (if applicable) and description of medical condition
0278U	Hematology (genetic thrombosis), genomic sequence analysis of 14 genes, blood, buccal swab, or amniotic fluid	Prior Authorization Required	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
0282U	Red blood cell antigen typing, DNA, genotyping of 12 blood group system genes to predict 44 red blood cell antigen phenotypes	Prior Authorization Required	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
0285U	Oncology, disease progression and response monitoring to radiation, chemotherapy, or other systematic cancer treatments, cell-free DNA, quantitative branched chain DNA amplification, plasma reported in as NG/ML a radiation toxicity score	Prior Authorization Required	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing

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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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing

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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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
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	Prior Authorization Required	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing

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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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
0308T	INSERTion of ocular telescope prosthesis including removal of crystalline lens or intraocular lens prosthesis	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history and physical, documentation of medical necessity.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
0308U	Cardiology (coronary artery disease [CAD]), analysis of 3 proteins (high sensitivity [hs] troponin, adiponectin, and kidney injury molecule-1 [KIM-1]) with 3 clinical parameters (age, sex, history of cardiac intervention), plasma, algorithm reported as a risk score for obstructive CAD	Advance Benefit Determination (ABD) recommended	Investigative	Submit procedure/testing report
0309U	Cardiology (cardiovascular disease), analysis of 4 proteins (NT-proBNP, osteopontin, tissue inhibitor of metalloproteinase-1 [TIMP-1], and kidney injury molecule-1 [KIM-1]), plasma, algorithm reported as a risk score for major adverse cardiac event	Advance Benefit Determination (ABD) recommended	Investigative	Submit procedure/testing report
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	Advance Benefit Determination (ABD) recommended	Investigative	Submit procedure/testing report
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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing

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Code List

Code	Description	Plan Review Requirement	Reviewed For	Records Request
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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
0318U	Pediatrics (congenital epigenetic disorders), whole genome methylation analysis by microarray for 50 or more genes, blood	Prior Authorization Required	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
0329T	Monitoring of intraocular pressure for 24 hours or longer, unilateral or bilateral, with interpretation and report	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history and physical, documentation of medical necessity.
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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
0331T	Myocardial sympathetic innervation imaging, planar qualitative and quantitative assessment;	Advance Benefit Determination (ABD) recommended	Investigative	History and physical, documentation of medical necessity, and procedure report
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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
0332T	Myocardial sympathetic innervation imaging, planar qualitative and quantitative assessment; with tomographic SPECT	Prior Authorization Required	Investigative	Submit history and physical and documentation of medical necessity, and procedure/imaging report
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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
0333T	Visual evoked potential, screening of visual acuity, automated, with report	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history and physical, documentation of medical necessity.
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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
0335T	Insertion of sinus tarsi implant.	Advance Benefit Determination (ABD) recommended	Investigative	Submit procedure/testing report

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Code List

Code	Description	Plan Review Requirement	Reviewed For	Records Request
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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
0338T	Transcatheter renal sympathetic denervation, percutaneous approach including arterial puncture, selective catheter placement(s) renal artery(ies), fluoroscopy, contrast injection(s), intraprocedural roadmapping and radiological supervision and interpretation, including pressure gradient measurements, flush aortogram and diagnostic renal angiography when performed; unilateral	Advance Benefit Determination (ABD) recommended	Investigative	Submit procedure/testing report

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
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	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history and physical, documentation of medical necessity.
0339T	Transcatheter renal sympathetic denervation, percutaneous approach including arterial puncture, selective catheter placement(s) renal artery(ies), fluoroscopy, contrast injection(s), intraprocedural roadmapping and radiological supervision and interpretation, including pressure gradient measurements, flush aortogram and diagnostic renal angiography when performed; bilateral	Advance Benefit Determination (ABD) recommended	Investigative	Submit procedure/testing report
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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing

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0341U	Fetal aneuploidy DNA sequencing comparative analysis, fetal DNA from products of conception, reported as normal (euploidy), monosomy, trisomy, or partial deletion/duplication, mosaicism, and segmental aneuploid	Prior Authorization Required	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
0342T	Therapeutic apheresis with selective HDL delipidation and plasma reinfusion	Advance Benefit Determination (ABD) recommended	Investigative	Submit history and physical, documentation of medical necessity.
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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
0345T	Transcatheter mitral valve repair percutaneous approach via the coronary sinus	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, documentation of medical necessity, and procedure 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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
0355U	APOL1 (apolipoprotein L1) (eg, chronic kidney disease), risk variants (G1, G2)	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history and physical, documentation of medical necessity.
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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
0358T	Bioelectrical impedance analysis whole body composition assessment, with interpretation and report	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history and physical, documentation of medical necessity.
0361U	Neurofilament light chain, digital immunoassay, plasma, quantitative	Advance Benefit Determination (ABD) recommended	Investigative	Submit procedure/testing report
0362T	Behavior identification supporting assessment, each 15 minutes of technicians' time face-to-face with a patient, requiring the following components: administration by the physician or other qualified health care professional who is on site; with the assistance of two or more technicians; for a patient who exhibits destructive behavior; completion in an environment that is customized to the patient's behavior.	Prior Authorization Required	Medical Necessity Review Required	For initial treatment: Submit clinical records including verification that autism spectrum disorder diagnosis was made by appropriate diagnosing provider, copy of functional behavioral assessment, treatment plan - including location of services and current Individualized Education Plan. For ongoing treatment: Submit clinical records that include the recent behavioral re-assessment, treatment plan update - including location of services and current Individualized Education Plan.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
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	Investigative	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
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	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, documentation of medical necessity, and procedure report

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Code List

Code	Description	Plan Review Requirement	Reviewed For	Records Request
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	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
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	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
0371U	Infectious agent detection by nucleic acid genitourinary pathogen, semiquantitative identification, DNA from 16 bacterial organisms & 1 fungal organism, multiplex amplified	Prior Authorization Required	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
0372U	Infectious disease, antibiotic-resistance gene detection, multiplex amplified probe technique, urine, reported as an antimicrobial stewardship risk score	Prior Authorization Required	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
0373T	Adaptive behavior treatment with protocol modification, each 15 minutes of technicians' time face-to-face with a patient, requiring the following components: administration	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, treatment plan
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	Advance Benefit Determination (ABD) recommended	Investigative	History and physical, documentation of medical necessity, and procedure report
0377U	Cardiovascular disease, quantification of advanced serum or plasma lipoprotein profile, by nuclear magnetic resonance (NMR) spectrometry with report of a lipoprotein profile	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
0378T	Visual field assessment, with concurrent real time data analysis and accessible data storage with patient initiated data transmitted to a remote surveillance center for up to 30 days; review and interpretation with report by a physician or other qualified health care professional	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history and physical, documentation of medical necessity.
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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
0379T	Visual field assessment, with concurrent real time data analysis and accessible data storage with patient initiated data transmitted to a remote surveillance center for up to 30 days; technical support and patient instructions, surveillance, analysis, and transmission of daily and emergent data reports as prescribed by a physician or other qualified health care professional	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history and physical, documentation of medical necessity.
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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
0384U	Nephrology carboxymethyllsine, methylgloxal hydroimidazolone, and carboxyethyl lysine by liquid chromatography with tandem mass spectrometry & HBA1C 4	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, documentation of medical necessity and procedure report, as well as reason for testing
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	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, documentation of medical necessity and procedure report, as well as reason for testing

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
0390U	Obstetrics (preeclampsia), kinase insert domain receptor (KDR), Endoglin (ENG), and retinol-binding protein 4 (RBP4), by immunoassay, serum, algorithum reported as risk score	Advance Benefit Determination (ABD) recommended	Investigative	Submit history and physical, documentation of medical necessity and procedure report.
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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
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	Prior Authorization Required	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
0397T	Endoscopic retrograde cholangiopancreatography (ERCP), with optical endomicroscopy (List separately in addition to code for primary procedure)	Advance Benefit Determination (ABD) recommended	Investigative	Submit procedure/testing report
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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
0405U	Oncology (pancreatic), 59 methylation haplotype block markers, next-generation sequencing, plasma, reported as cancer signal detected or not detected	Prior Authorization Required	Investigative	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing

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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	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
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	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
0409T	INSERTion or replacement of permanent cardiac contractility modulation system, including contractility evaluation when performed, and programming of sensing and therapeutic parameters; pulse generator only	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
0410T	INSERTion or replacement of permanent cardiac contractility modulation system, including contractility evaluation when performed, and programming of sensing and therapeutic parameters; atrial electrode only	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, documentation of medical necessity, and 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	Investigative	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
0411T	INSERTion or replacement of permanent cardiac contractility modulation system, including contractility evaluation when performed, and programming of sensing and therapeutic parameters; ventricular electrode only	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, documentation of medical necessity, and 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	Investigative	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
0412T	Removal of permanent cardiac contractility modulation system; pulse generator only	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
0413T	Removal of permanent cardiac contractility modulation system; transvenous electrode (atrial or ventricular)	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
0414T	Removal and replacement of permanent cardiac contractility modulation system pulse generator only	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, documentation of medical necessity, and 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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
0415T	Repositioning of previously implanted cardiac contractility modulation transvenous electrode, (atrial or ventricular lead)	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, documentation of medical necessity, and procedure report

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
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	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, documentation of medical necessity, and reason for testing
0416T	Relocation of skin pocket for implanted cardiac contractility modulation pulse generator	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
0417T	Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed VALUES with analysis, including review and report, implantable cardiac contractility modulation system	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
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	Investigative	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
0418T	Interrogation device evaluation (in person) with analysis, review and report, includes connection, recording and disconnection per patient encounter, implantable cardiac contractility modulation system	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
0419T	Destruction of neurofibroma, extensive (cutaneous, dermal extending into subcutaneous); face, head and neck, greater than 50 neurofibromas	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
0420T	Destruction of neurofibroma, extensive (cutaneous, dermal extending into subcutaneous); trunk and extremities, extensive, greater than 100 neurofibromas	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
0421U	Oncology (colorectal) screening, quantitative real-time target & signal amplification of 8 RNA markers & fecal hemoglobin, algorithm reported as A+ or - for colorectal cancer	Prior Authorization Required	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
0422T	Tactile breast imaging by computer-aided tactile sensors, unilateral or bilateral	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
0425U	Genome (eg, unexplained constitutional or heritable disorder or syndrome), rapid sequence analysis, each comparator genome (eg parents, siblings)	Prior Authorization Required	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
0426U	Genome (eg, unexplained constitutional or heritable disorder or syndrome), ultra-rapid sequence analysis	Prior Authorization Required	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
0434U	Drug metabolism (adverse drug reactions and drug response), genomic analysis panel, variant analysis of 25 genes with reported phenotypes	Prior Authorization Required	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
0437T	Implantation of non-biologic or synthetic implant (eg, polypropylene) for fascial reinforcement of the abdominal wall (List separately in addition to code for primary procedure)	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history and physical, documentation of medical necessity and procedure report.
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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
0439T	Myocardial contrast perfusion echocardiography, at rest or with stress, for assessment of myocardial ischemia or viability (List separately in addition to code for primary procedure)	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history and physical, documentation of medical necessity and procedure report.

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Code List

Code	Description	Plan Review Requirement	Reviewed For	Records Request
0440T	Ablation, percutaneous, cryoablation, includes imaging guidance; upper extremity distal/peripheral nerve	Advance Benefit Determination (ABD) recommended	Investigative	Submit procedure/testing report
0441T	Ablation, percutaneous, cryoablation, includes imaging guidance; lower extremity distal/peripheral nerve	Advance Benefit Determination (ABD) recommended	Investigative	Submit procedure/testing report
0442T	Ablation, percutaneous, cryoablation, includes imaging guidance; nerve plexus or other truncal nerve (eg, brachial plexus, pudendal nerve)	Advance Benefit Determination (ABD) recommended	Investigative	Submit procedure/testing report
0443T	Real-time spectral analysis of prostate tissue by fluorescence spectroscopy, including imaging guidance (List separately in addition to code for primary procedure)	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
0464T	Visual evoked potential, testing for glaucoma, with interpretation and report	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
0464U	Oncology (colorectal) screening, quantitative real-time target and signal amplification, methylated DNA markers, including LASS4, LRRC4 and PPP2R5C, a reference marker ZDHHC1, and a protein marker (fecal hemoglobin), utilizing stool, algorithm reported as a positive or negative result	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, documentation of medical necessity, and reason for testing
0469T	Retinal polarization scan, ocular screening with on-site automated results, bilateral	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, documentation of medical necessity, and procedure report

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Code List

Code	Description	Plan Review Requirement	Reviewed For	Records Request
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	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, documentation of medical necessity, and reason for testing
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	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, documentation of medical necessity, and reason for testing
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	Advance Benefit Determination (ABD) recommended	Investigative	Submit procedure/testing report
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	Advance Benefit Determination (ABD) recommended	Investigative	Submit procedure/testing report

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
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	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, documentation of medical necessity, and reason for testing
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	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, documentation of medical necessity, and reason for testing
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	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
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)	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
0481T	Injection(s), autologous white blood cell concentrate (autologous protein solution), any site, including image guidance, harvesting and preparation, when performed	Advance Benefit Determination (ABD) recommended	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
0483T	Transcatheter mitral valve implantation/replacement (TMVI) with prosthetic valve; percutaneous approach, including transseptal puncture, when performed	Advance Benefit Determination (ABD) recommended	Medical Necessity	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)	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
0485T	Optical coherence tomography (OCT) of middle ear, with interpretation and report; unilateral	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
0486T	Optical coherence tomography (OCT) of middle ear, with interpretation and report; bilateral	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, documentation of medical necessity, and 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	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
0490T	Autologous adipose-derived regenerative cell therapy for scleroderma in the hands; multiple injections in one or both hands	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
0494T	Surgical preparation and cannulation of marginal (extended) cadaver donor lung(s) to ex vivo organ perfusion system, including decannulation, separation from the perfusion system, and cold preservation of the allograft prior to implantation, when performed	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, documentation of medical necessity, and procedure report

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
0495T	Initiation and monitoring marginal (extended) cadaver donor lung(s) organ perfusion system by physician or qualified health care professional, including physiological and laboratory assessment (eg, pulmonary artery flow, pulmonary artery pressure, left atrial pressure, pulmonary vascular resistance, mean/peak and plateau airway pressure, dynamic compliance and perfusate gas analysis), including bronchoscopy and X ray when performed; first two hours in sterile field	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
0496T	Initiation and monitoring marginal (extended) cadaver donor lung(s) organ perfusion system by physician or qualified health care professional, including physiological and laboratory assessment (eg, pulmonary artery flow, pulmonary artery pressure, left atrial pressure, pulmonary vascular resistance, mean/peak and plateau airway pressure, dynamic compliance and perfusate gas analysis), including bronchoscopy and X ray when performed; each additional hour (List separately in addition to code for primary procedure)	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
0506T	Macular pigment optical density measurement by heterochromatic flicker photometry, unilateral or bilateral, with interpretation and report	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
0509T	Electroretinography (ERG) with interpretation and report, pattern (PERG)	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
0511T	Removal and reinsertion of sinus tarsi implant	Prior Authorization Required	Investigative	Submit procedure/testing report

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
0512T	Extracorporeal shock wave for integumentary wound healing, including topical application and dressing care; initial wound	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
0513T	Extracorporeal shock wave for integumentary wound healing, including topical application and dressing care; each additional wound (List separately in addition to code for primary procedure)	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
0515T	INSERTion of wireless cardiac stimulator for left ventricular pacing, including device interrogation and programming, and imaging supervision and interpretation, when performed; complete system (includes electrode and generator [transmitter and battery])	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
0516T	INSERTion of wireless cardiac stimulator for left ventricular pacing, including device interrogation and programming, and imaging supervision and interpretation, when performed; electrode only	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
0517T	INSERTion of wireless cardiac stimulator for left ventricular pacing, including device interrogation and programming, and imaging supervision and interpretation, when performed; both components of pulse generator (battery and transmitter) only	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
0518T	Removal of pulse generator for wireless cardiac stimulator for left ventricular pacing; battery component only	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, documentation of medical necessity, and procedure report

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
0519T	Removal and replacement of pulse generator for wireless cardiac stimulator for left ventricular pacing, including device interrogation and programming; both components (battery and transmitter)	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
0520T	Removal and replacement of pulse generator for wireless cardiac stimulator for left ventricular pacing, including device interrogation and programming; battery component only	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
0521T	Interrogation device evaluation (in person) with analysis, review and report, includes connection, recording, and disconnection per patient encounter, wireless cardiac stimulator for left ventricular pacing	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
0522T	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, wireless cardiac stimulator for left ventricular pacing	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
0523T	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 (List separately in addition to code for primary procedure)	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, documentation of medical necessity, and procedure report

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0524T	Endovenous catheter directed chemical ablation with balloon isolation of incompetent extremity vein, open or percutaneous, including all vascular access, catheter manipulation, diagnostic imaging, imaging guidance and monitoring	Prior Authorization Required	Medical Necessity	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	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, documentation of medical necessity, and reason for testing
0525T	INSERTion or replacement of intracardiac ischemia monitoring system, including testing of the lead and monitor, initial system programming, and imaging supervision and interpretation; complete system (electrode and implantable monitor)	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
0526T	INSERTion or replacement of intracardiac ischemia monitoring system, including testing of the lead and monitor, initial system programming, and imaging supervision and interpretation; electrode only	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
0527T	INSERTion or replacement of intracardiac ischemia monitoring system, including testing of the lead and monitor, initial system programming, and imaging supervision and interpretation; implantable monitor only	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
0528T	Programming device evaluation (in person) of intracardiac ischemia monitoring system with iterative adjustment of programmed VALUES, with analysis, review, and report	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, documentation of medical necessity, and procedure report

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0529T	Interrogation device evaluation (in person) of intracardiac ischemia monitoring system with analysis, review, and report	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
0530T	Removal of intracardiac ischemia monitoring system, including all imaging supervision and interpretation; complete system (electrode and implantable monitor)	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
0531T	Removal of intracardiac ischemia monitoring system, including all imaging supervision and interpretation; electrode only	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
0532T	Removal of intracardiac ischemia monitoring system, including all imaging supervision and interpretation; implantable monitor only	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, documentation of medical necessity, and 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	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, documentation of medical necessity, and reason for testing
0541T	Myocardial imaging by magnetocardiography (MCG) for detection of cardiac ischemia, by signal acquisition using minimum 36 channel grid, generation of magnetic-field time-series images, quantitative analysis of magnetic dipoles, machine learning-derived clinical scoring, and automated report generation, single study	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, documentation of medical necessity, and procedure report

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0542T	Myocardial imaging by magnetocardiography (MCG) for detection of cardiac ischemia, by signal acquisition using minimum 36 channel grid, generation of magnetic-field time-series images, quantitative analysis of magnetic dipoles, machine learning-derived clinical scoring, and automated report generation, single study; interpretation and report	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
0543T	Transapical mitral valve repair, including transthoracic echocardiography, when performed, with placement of artificial chordae tendineae	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
0544T	Transcatheter mitral valve annulus reconstruction, with implantation of adjustable annulus reconstruction device, percutaneous approach including transseptal puncture	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
0545T	Transcatheter tricuspid valve annulus reconstruction with implantation of adjustable annulus reconstruction device, percutaneous approach	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
0546T	Radiofrequency spectroscopy, real time, intraoperative margin assessment, at the time of partial mastectomy, with report	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
0547T	Bone-material quality testing by microindentation(s) of the tibia(s), with results reported as a score	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history and physical, documentation of medical necessity.

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0554T	Bone strength and fracture risk using finite element analysis of functional data and bone-mineral density, utilizing data from a computed tomography scan; retrieval and transmission of the scan data, assessment of bone strength and fracture risk and bone mineral density, interpretation and report	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history and physical, documentation of medical necessity.
0555T	Bone strength and fracture risk using finite element analysis of functional data, and bone-mineral density, utilizing data from a computed tomography scan; retrieval and transmission of the scan data	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history and physical, documentation of medical necessity.
0556T	Bone strength and fracture risk using finite element analysis of functional data, and bone-mineral density, utilizing data from a computed tomography scan; assessment of bone strength and fracture risk and bone mineral density	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history and physical, documentation of medical necessity.
0557T	Bone strength and fracture risk using finite element analysis of functional data, and bone-mineral density, utilizing data from a computed tomography scan; interpretation and report	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history and physical, documentation of medical necessity.
0558T	Computed tomography scan taken for the purpose of biomechanical computed tomography analysis	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history and physical, documentation of medical necessity.
0559T	Anatomic model 3D-printed from image data set(s); first individually prepared and processed component of an anatomic structure	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history and physical, documentation of medical necessity.
0560T	Anatomic model 3D-printed from image data set(s); each additional individually prepared and processed component of an anatomic structure (List separately in addition to code for primary procedure)	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history and physical, documentation of medical necessity.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
0561T	Anatomic guide 3D-printed and designed from image data set(s); first anatomic guide	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history and physical, documentation of medical necessity.
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)	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history and physical, documentation of medical necessity.
0563T	Evacuation of meibomian glands, using heat delivered through wearable, open-eye eyelid treatment devices and manual gland expression, bilateral	Advance Benefit Determination (ABD) recommended	Investigative	Submit procedure/testing report
0565T	Autologous cellular implant derived from adipose tissue for the treatment of osteoarthritis of the knees; tissue harvesting and cellular implant creation	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history and physical, documentation of medical necessity.
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	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history and physical, documentation of medical necessity.
0569T	Transcatheter tricuspid valve repair, percutaneous approach; initial prosthesis	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history and physical, documentation of medical necessity.
0570T	Transcatheter tricuspid valve repair, percutaneous approach; each additional prosthesis during same session (List separately in addition to code for primary procedure)	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history and physical, documentation of medical necessity.

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Code List

Code	Description	Plan Review Requirement	Reviewed For	Records Request
0571T	Insertion or replacement of implantable cardioverter-defibrillator system with substernal electrode(s), including all imaging guidance and electrophysiological evaluation (includes defibrillation threshold evaluation, induction of arrhythmia, evaluation of sensing for arrhythmia termination, and programming or reprogramming of sensing or therapeutic parameters), when performed	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history and physical, documentation of medical necessity.
0572T	Insertion of substernal implantable defibrillator electrode	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history and physical, documentation of medical necessity.
0573T	Removal of substernal implantable defibrillator electrode	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history and physical, documentation of medical necessity.
0574T	Repositioning of previously implanted substernal implantable defibrillator-pacing electrode	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history and physical, documentation of medical necessity.
0575T	Programming device evaluation (in person) of implantable cardioverter-defibrillator system with substernal electrode, 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	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history and physical, documentation of medical necessity.
0576T	Interrogation device evaluation (in person) of implantable cardioverter-defibrillator system with substernal electrode, with analysis, review and report by a physician or other qualified health care professional, includes connection, recording and disconnection per patient encounter	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history and physical, documentation of medical necessity.

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Code List

Code	Description	Plan Review Requirement	Reviewed For	Records Request
0577T	Electrophysiologic evaluation of implantable cardioverter-defibrillator system with substernal electrode (includes defibrillation threshold evaluation, induction of arrhythmia, evaluation of sensing for arrhythmia termination, and programming or reprogramming of sensing or therapeutic parameters)	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history and physical, documentation of medical necessity.
0578T	Interrogation device evaluation(s) (remote), up to 90 days, substernal lead implantable cardioverter-defibrillator system with interim analysis, review(s) and report(s) by a physician or other qualified health care professional	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history and physical, documentation of medical necessity.
0579T	Interrogation device evaluation(s) (remote), up to 90 days, substernal lead implantable cardioverter-defibrillator system, remote data acquisition(s), receipt of transmissions and technician review, technical support and distribution of results	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history and physical, documentation of medical necessity.
0581T	Ablation, malignant breast tumor(s), percutaneous, cryotherapy, including imaging guidance when performed, unilateral	Advance Benefit Determination (ABD) recommended	Investigative	Submit procedure/testing report
0582T	Transurethral ablation of malignant prostate tissue by high-energy water vapor thermotherapy, including intraoperative imaging and needle guidance	Advance Benefit Determination (ABD) recommended	Investigative	Submit procedure/testing report
0583T	Tympanostomy (requiring INSERTion of ventilating tube), using an automated tube delivery system, iontophoresis local anesthesia	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history and physical, documentation of medical necessity.

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Code List

Code	Description	Plan Review Requirement	Reviewed For	Records Request
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	If transplant approval on record, then provide date of transplant; if no transplant approval on record, then provide history and physical, transplant evaluation, and date of transplant
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	If transplant approval on record, then provide date of transplant; if no transplant approval on record, then provide history and physical, transplant evaluation, and date of transplant
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	If transplant approval on record, then provide date of transplant; if no transplant approval on record, then provide history and physical, transplant evaluation, and date of transplant
0588T	Revision or removal of percutaneously placed integrated single device neurostimulation system for bladder dysfunction including electrode array and receiver or pulse generator, including analysis, programming, and imaging guidance when performed, posterior tibial nerve	Prior Authorization Required	Medical Necessity	Submit history and physical and documentation of medical necessity, and procedure/imaging report

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Code List

Code	Description	Plan Review Requirement	Reviewed For	Records Request
0589T	Electronic analysis with simple programming of implanted integrated neurostimulation system for bladder dysfunction (eg, electrode array and receiver), including contact group(s), amplitude, pulse width, frequency (Hz), on/off cycling, burst, dose lockout, patient-selectable parameters, responsive neurostimulation, detection algorithms, closed-loop parameters, and passive parameters, when performed by physician or other qualified health care professional, posterior tibial nerve, 1-3 parameters	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history and physical, documentation of medical necessity.
0590T	Electronic analysis with complex programming of implanted integrated neurostimulation system for bladder dysfunction (eg, electrode array and receiver), including contact group(s), amplitude, pulse width, frequency (Hz), on/off cycling, burst, dose lockout, patient-selectable parameters, responsive neurostimulation, detection algorithms, closed-loop parameters, and passive parameters, when performed by physician or other qualified health care professional, posterior tibial nerve, 4 or more parameters	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history and physical, documentation of medical necessity.
0591T	Health and well-being coaching face-to-face; individual, initial assessment	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
0592T	Health and well-being coaching face-to-face; individual, follow-up session, at least 30 minutes	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
0593T	Health and well-being coaching face-to-face; group (2 or more individuals), at least 30 minutes	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.

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Code List

Code	Description	Plan Review Requirement	Reviewed For	Records Request
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	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
0596T	Temporary female intraurethral valve-pump (ie, voiding prosthesis); initial insertion, including urethral measurement	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
0597T	Temporary female intraurethral valve-pump (ie, voiding prosthesis); replacement	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
0598T	Real-time fluorescence wound imaging with clinical darkness, to identify location of bacterial wound pathogens and measure wound size, per session; first anatomic site (e.g., lower extremity, right leg)	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
0599T	Real-time fluorescence wound imaging with clinical darkness, to identify location of bacterial wound pathogens and measure wound size, per session; each additional anatomic site (e.g., upper extremity, left leg) (List separately in addition to code for primary procedure)	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
0600T	Ablation, irreversible electroporation; 1 or more tumors per organ, including imaging guidance, when performed, percutaneous	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
0601T	Ablation, irreversible electroporation; 1 or more tumors, including fluoroscopic and ultrasound guidance, when performed, open	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, documentation of medical necessity, and procedure report

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Code List

Code	Description	Plan Review Requirement	Reviewed For	Records Request
0602T	Glomerular filtration rate (GFR) measurement(s), transdermal, including sensor placement and administration of a single dose of fluorescent pyrazine agent	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
0603T	Glomerular filtration rate (GFR) monitoring, transdermal, including sensor placement and administration of more than one dose of fluorescent pyrazine agent, each 24 hours	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
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	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
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	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
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	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, documentation of medical necessity, and procedure report

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Code List

Code	Description	Plan Review Requirement	Reviewed For	Records Request
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	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
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	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
0609T	Magnetic resonance spectroscopy, determination and localization of discogenic pain (cervical, thoracic, or lumbar); acquisition of single voxel data, per disc, on biomarkers (ie, lactic acid, carbohydrate, alanine, laal, propionic acid, proteoglycan, and collagen) in at least 3 discs	Prior Authorization Required	Medical Necessity	Submit history and physical and documentation of medical necessity, and procedure/imaging report
0610T	Magnetic resonance spectroscopy, determination and localization of discogenic pain (cervical, thoracic, or lumbar); transmission of biomarker data for software analysis	Prior Authorization Required	Medical Necessity	Submit history and physical and documentation of medical necessity, and procedure/imaging report

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Code List

Code	Description	Plan Review Requirement	Reviewed For	Records Request
0611T	Magnetic resonance spectroscopy, determination and localization of discogenic pain (cervical, thoracic, or lumbar); postprocessing for algorithmic analysis of biomarker data for determination of relative chemical differences between discs	Prior Authorization Required	Medical Necessity	Submit history and physical and documentation of medical necessity, and procedure/imaging report
0612T	Magnetic resonance spectroscopy, determination and localization of discogenic pain (cervical, thoracic, or lumbar); interpretation and report	Prior Authorization Required	Medical Necessity	Submit history and physical and documentation of medical necessity, and procedure/imaging report
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	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
0614T	REMOVAL AND REPLACEMENT OF SUBSTERNAL IMPLANTABLE DEFIBRILLATOR PULSE GENERATOR	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
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	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
0619T	Cystourethroscopy with transurethral anterior prostate commissurotomy and drug delivery, including transrectal ultrasound and fluoroscopy, when performed	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, documentation of medical necessity, and procedure report

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
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	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
0621T	Trabeculostomy ab interno by laser	Advance Benefit Determination (ABD) recommended	Investigative	Submit history and physical, documentation of medical necessity and procedure report.
0622T	Trabeculostomy ab interno by laser; with use of ophthalmic endoscope	Advance Benefit Determination (ABD) recommended	Investigative	Submit history and physical, documentation of medical necessity and procedure report.
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	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
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	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, documentation of medical necessity, and procedure report

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Code List

Code	Description	Plan Review Requirement	Reviewed For	Records Request
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	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
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	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
0627T	Percutaneous injection of allogeneic cellular and/or tissue-based product, intervertebral disc, unilateral or bilateral injection, with fluoroscopic guidance, lumbar; first level	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
0628T	Percutaneous injection of allogeneic cellular and/or tissue-based product, intervertebral disc, unilateral or bilateral injection, with fluoroscopic guidance, lumbar; each additional level (List separately in addition to code for primary procedure)	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
0629T	Percutaneous injection of allogeneic cellular and/or tissue-based product, intervertebral disc, unilateral or bilateral injection, with CT guidance, lumbar; first level	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, documentation of medical necessity, and procedure report

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Code List

Code	Description	Plan Review Requirement	Reviewed For	Records Request
0630T	Percutaneous injection of allogeneic cellular and/or tissue-based product, intervertebral disc, unilateral or bilateral injection, with CT guidance, lumbar; each additional level (List separately in addition to code for primary procedure)	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
0631T	Transcutaneous visible light hyperspectral imaging measurement of oxyhemoglobin, deoxyhemoglobin, and tissue oxygenation, with interpretation and report, per extremity	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
0632T	Percutaneous transcatheter ultrasound ablation of nerves innervating the pulmonary arteries, including right heart catheterization, pulmonary artery angiography, and all imaging guidance	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
0633T	Computed tomography, breast, including 3D rendering, when performed, unilateral; without contrast material	Prior Authorization Required	Medical Necessity	Submit history and physical and documentation of medical necessity, and procedure/imaging report
0634T	Computed tomography, breast, including 3D rendering, when performed, unilateral; with contrast material(s)	Prior Authorization Required	Medical Necessity	Submit history and physical and documentation of medical necessity, and procedure/imaging report
0635T	Computed tomography, breast, including 3D rendering, when performed, unilateral; without contrast, followed by contrast material(s)	Prior Authorization Required	Medical Necessity	Submit history and physical and documentation of medical necessity, and procedure/imaging report
0636T	Computed tomography, breast, including 3D rendering, when performed, bilateral; without contrast material(s)	Prior Authorization Required	Medical Necessity	Submit history and physical and documentation of medical necessity, and procedure/imaging report
0637T	Computed tomography, breast, including 3D rendering, when performed, bilateral; with contrast material(s)	Prior Authorization Required	Medical Necessity	Submit history and physical and documentation of medical necessity, and procedure/imaging report
0638T	Computed tomography, breast, including 3D rendering, when performed, bilateral; without contrast, followed by contrast material(s)	Prior Authorization Required	Medical Necessity	Submit history and physical and documentation of medical necessity, and procedure/imaging report

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0640T	Noncontact near-infrared spectroscopy (eg, for measurement of deoxyhemoglobin, oxyhemoglobin, and ratio of tissue oxygenation), other than for screening for peripheral arterial disease, image acquisition, interpretation, and report; first anatomic site	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
0643T	Transcatheter left ventricular restoration device implantation including right and left heart catheterization and left ventriculography when performed, arterial approach	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
0644T	Transcatheter removal or debulking of intracardiac mass (eg, vegetations, thrombus) via suction (eg, vacuum, aspiration) device, percutaneous approach, with intraoperative reinfusion of aspirated blood, including imaging guidance, when performed	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
0645T	Transcatheter implantation of coronary sinus reduction device including vascular access and closure, right heart catheterization, venous angiography, coronary sinus angiography, imaging guidance, and supervision and interpretation, when performed	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
0646T	Transcatheter tricuspid valve implantation (TTVI)/replacement with prosthetic valve, percutaneous approach, including right heart catheterization, temporary pacemaker INSERTion, and selective right ventricular or right atrial angiography, when performed	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, documentation of medical necessity, and procedure report

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
0647T	INSERTion of gastrostomy tube, percutaneous, with magnetic gastropexy, under ultrasound guidance, image documentation and report	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
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	Medical Necessity	Submit history and physical and documentation of medical necessity, and procedure/imaging report
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	Medical Necessity	Submit history and physical and documentation of medical necessity, and procedure/imaging report
0650T	Programming device evaluation (remote) of subcutaneous cardiac rhythm monitor system, with iterative adjustment of the implantable device to test the function of the device and select optimal permanently programmed VALUES with analysis, review and report by a physician or other qualified health care professional	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history and physical, documentation of medical necessity.

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Code List

Code	Description	Plan Review Requirement	Reviewed For	Records Request
0651T	Magnetically controlled capsule endoscopy, esophagus through stomach, including intraprocedural positioning of capsule, with interpretation and report	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
0652T	Esophagogastroduodenoscopy, flexible, transnasal; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
0653T	Esophagogastroduodenoscopy, flexible, transnasal; with biopsy, single or multiple	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
0654T	Esophagogastroduodenoscopy, flexible, transnasal; with INSERTion of intraluminal tube or catheter	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
0655T	Transperineal focal laser ablation of malignant prostate tissue, including transrectal imaging guidance with mr-fused images or other enhanced ultrasound imaging	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
0656T	Anterior lumbar or thoracolumbar vertebral body tethering; up to 7 vertebral segments	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
0657T	Anterior lumbar or thoracolumbar vertebral body tethering; 8 or more vertebral segments	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
0658T	Electrical impedance spectroscopy of 1 or more skin lesions for automated melanoma risk score	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, documentation of medical necessity, and procedure report

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
0659T	Transcatheter intracoronary infusion of supersaturated oxygen in conjunction with percutaneous coronary revascularization during acute myocardial infarction, including catheter placement, imaging guidance (eg, fluoroscopy), angiography, and radiologic supervision and interpretation	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
0660T	Implantation of anterior segment intraocular nonbiodegradable drug-eluting system, internal approach	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
0661T	Removal and reimplantation of anterior segment intraocular nonbiodegradable drug-eluting implant	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
0662T	Scalp cooling, mechanical; initial measurement and calibration of cap	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
0663T	Scalp cooling, mechanical; placement of device monitoring and removal of device	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
0664T	Donor hysterectomy (including cold preservation); open, from cadaver donor	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
0665T	Donor hysterectomy (including cold preservation); open, from living donor	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
0666T	Donor hysterectomy (including cold preservation); laparoscopic or robotic, from living donor	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
0667T	Donor hysterectomy (including cold preservation); recipient uterus allograft transplantation from cadaver or living donor	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.

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Code List

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	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
0669T	Backbench reconstruction of cadaver or living donor uterus allograft prior to transplantation; venous anastomosis, each	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
0670T	Backbench reconstruction of cadaver or living donor uterus allograft prior to transplantation; arterial anastomosis, each	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
0672T	Endovaginal cryogen-cooled, monopolar radiofrequency remodeling of the tissues surrounding the female bladder neck and proximal urethra for urinary incontinence	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history and physical, documentation of medical necessity.
0673T	Ablation, benign thyroid nodule(s), percutaneous, laser, including imaging guidance	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history and physical, documentation of medical necessity.
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)	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history and physical, documentation of medical necessity.
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	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history and physical, documentation of medical necessity.

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Code List

Code	Description	Plan Review Requirement	Reviewed For	Records Request
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)	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history and physical, documentation of medical necessity.
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	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history and physical, documentation of medical necessity.
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)	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history and physical, documentation of medical necessity.
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)	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history and physical, documentation of medical necessity.
0681T	Relocation of pulse generator only, permanent implantable synchronized diaphragmatic stimulation system for augmentation of cardiac function, with connection to existing dual leads	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history and physical, documentation of medical necessity.

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Code List

Code	Description	Plan Review Requirement	Reviewed For	Records Request
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	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history and physical, documentation of medical necessity.
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	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history and physical, documentation of medical necessity.
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	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history and physical, documentation of medical necessity.
0686T	Histotripsy (ie, non-thermal ablation via acoustic energy delivery) of malignant hepatocellular tissue, including image guidance	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history and physical, documentation of medical necessity.

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Code List

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)	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history and physical, documentation of medical necessity.
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)	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history and physical, documentation of medical necessity.
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	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history and physical, documentation of medical necessity.
0692T	Therapeutic ultrafiltration	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history and physical, documentation of medical necessity.
0693T	Comprehensive full body computer-based markerless 3D kinematic and kinetic motion analysis and report	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history and physical, documentation of medical necessity.
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	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history and physical, documentation of medical necessity.

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Code List

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	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history and physical, documentation of medical necessity.
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	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history and physical, documentation of medical necessity.
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	Prior Authorization Required	Medical Necessity	Submit history and physical and documentation of medical necessity, and procedure/imaging report
0698T	Quantitative magnetic resonance for analysis of tissue composition (eg, fat, iron, water content), including multiparametric data acquisition, data preparation and transmission, interpretation and report, obtained with diagnostic MRI examination of the same anatomy (eg, organ, gland, tissue, target structure); multiple organs (List separately in addition to code for primary procedure)	Prior Authorization Required	Medical Necessity	Submit history and physical and documentation of medical necessity, and procedure/imaging report

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0700T	Molecular fluorescent imaging of suspicious nevus; first lesion	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history and physical, documentation of medical necessity.
0701T	Molecular fluorescent imaging of suspicious nevus; each additional lesion (List separately in addition to code for primary procedure)	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history and physical, documentation of medical necessity.
0704T	Remote treatment of amblyopia using an eye tracking device; device supply with initial set-up and patient education on use of equipment	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history and physical, documentation of medical necessity.
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	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history and physical, documentation of medical necessity.
0706T	Remote treatment of amblyopia using an eye tracking device; interpretation and report by physician or other qualified health care professional, per calendar month	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history and physical, documentation of medical necessity.
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	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history and physical, documentation of medical necessity.
0708T	Intradermal cancer immunotherapy; preparation and initial injection	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
0709T	Intradermal cancer immunotherapy; each additional injection (List separately in addition to code for primary procedure)	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.

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Code List

Code	Description	Plan Review Requirement	Reviewed For	Records Request
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	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history and physical, documentation of medical necessity.
0711T	Noninvasive arterial plaque analysis using software processing of data from non-coronary computerized tomography angiography; data preparation and transmission	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history and physical, documentation of medical necessity.
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	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history and physical, documentation of medical necessity.
0713T	Noninvasive arterial plaque analysis using software processing of data from non-coronary computerized tomography angiography; data review, interpretation and report	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history and physical, documentation of medical necessity.
0717T	Autologous adipose-derived regenerative cell (ADRC) therapy for partial thickness rotator cuff tear; adipose tissue harvesting, isolation and preparation of harvested cells, including incubation with cell dissociation enzymes, filtration, washing and concentration of ADRCs	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, and procedure report

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Code List

Code	Description	Plan Review Requirement	Reviewed For	Records Request
0718T	Autologous adipose-derived regenerative cell (ADRC) therapy for partial thickness rotator cuff tear; injection into supraspinatus tendon including ultrasound guidance, unilateral	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
0719T	Posterior vertebral joint replacement, including bilateral facetectomy, laminectomy, and radical discectomy, including imaging guidance, lumbar spine, single segment	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
0731T	Augmentative AI-based facial phenotype analysis with report	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
0732T	Immunotherapy administration with electroporation, intramuscular	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
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	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
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	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
0736T	Colonic lavage, 35 or more liters of water, gravity-fed, with induced defecation, including insertion of rectal catheter	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
0737T	Xenograft implantation into the articular surface	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
0740T	Remote autonomous algorithm-based recommendation system for insulin dose calculation and titration; initial set-up and patient education	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
0741T	Remote autonomous algorithm-based recommendation system for insulin dose calculation and titration; provision of software, data collection, transmission, and storage, each 30 days	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
0742T	Absolute quantitation of myocardial blood flow (AQMBF), single-photon emission computed tomography (SPECT), with exercise or pharmacologic stress, and at rest, when performed (List separately in addition to code for primary procedure)	Prior Authorization Required	Medical Necessity	Submit history and physical and documentation of medical necessity, and procedure/imaging report
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)	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
0765T	Assistive algorithmic electrocardiogram risk-based assessment for cardiac dysfunction (eg, low-ejection fraction, pulmonary hypertension, hypertrophic cardiomyopathy); related to previously performed electrocardiogram	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.

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Code List

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	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
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)	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
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	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.

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Code List

Code	Description	Plan Review Requirement	Reviewed For	Records Request
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)	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
0791T	Motor-cognitive, semi-immersive virtual reality-facilitated gait training, each 15 minutes (List separately in addition to code for primary procedure)	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
0792T	Application of silver diamine fluoride 38%, by a physician or other qualified health care professional	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
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	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.

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Code List

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)	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	Submit history and physical, documentation of medical necessity.
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)	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	Submit history and physical, documentation of medical necessity.
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)	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 List

Code	Description	Plan Review Requirement	Reviewed For	Records Request
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)	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	Submit history and physical, documentation of medical necessity.
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	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	Submit history and physical, documentation of medical necessity.
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)	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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0804T	Programming device evaluation (in person) with iterative adjustment of implantable device to test the function of device and to select optimal permanent programmed VALUES, with analysis, review, and report, by a physician or other qualified health care professional, leadless pacemaker system in dual cardiac chambers	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	Submit history and physical, documentation of medical necessity.
0805T	Transcatheter superior and inferior vena cava prosthetic valve implantation (ie, caval valve implantation [CAVI]); percutaneous femoral vein approach	Medical necessity review will be performed upon claims submission with supporting documentation	Investigative	Submit history and physical, documentation of medical necessity and procedure report.
0806T	Transcatheter superior and inferior vena cava prosthetic valve implantation (ie, caval valve implantation [CAVI]); open femoral vein approach	Medical necessity review will be performed upon claims submission with supporting documentation	Investigative	Submit history and physical, documentation of medical necessity and procedure report.
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	Medical necessity review will be performed upon claims submission with supporting documentation	Investigative	Submit history and physical, documentation of medical necessity and procedure report.
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	Prior Authorization Required	Investigative	Submit history and physical and documentation of medical necessity, and procedure/imaging report

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0810T	Subretinal injection of a pharmacologic agent, including vitrectomy and 1 or more retinotomies	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	Submit history and physical, documentation of medical necessity.
0811T	Remote multi-day complex uroflommetry (eg, calibrated electronic equipment); set-up and patient education on use of equipment	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
0812T	Remote multi-day complex uroflommetry device supply with automated report generation, up to 10 days	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
0813T	Esophagogastroduodenoscopy, flexible, transoral, with volume adjustment of intragastric bariatric balloon	Prior Authorization Required	Medical Necessity	Office evaluation, including height and weight, treatment plan, and nutritional/dietician and mental health evaluations/visits
0814T	Percutaneous injection of calcium-based biodegradable osteoconductive material, proximal femur, including imaging guidance, unilateral	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	Submit history and physical, documentation of medical necessity and procedure report.
0815T	Ultrasound-based radiofrequency echographic multi-spectrometry (REMS), bone-density study and fracture-risk assessment, 1 or more sites, hips, pelvis, or spine	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	Submit history and physical, documentation of medical necessity and procedure report.
0816T	Open insertion or replacement of integrated neurostimulation system for bladder dysfunction including electrode(s) & pulse generator or receiver including analysis, programming & guidance	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	Submit history and physical, documentation of medical necessity and procedure report.
0817T	Open insertion or replacement of integrated neurostimulation system for bladder dysfunction including electrode(s) & pulse generator or receiver including analysis, programming & imaging	Medical necessity review will be performed upon claims submission with supporting documentation	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
0818T	Revision or removal of integrated neurostimulation system for bladder dysfunction, including analysis, programming & imaging, when performed, posterior tibial nerve; subcutaneous	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	Submit history and physical, documentation of medical necessity and procedure report.
0819T	Revision or removal of integrated neurostimulation system for bladder dysfunction, including analysis, programming & imaging, when performed, posterior tibial nerve; subfascial	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	Submit history and physical, documentation of medical necessity and procedure report.
0820T	Continuous in-person monitoring & intervention as needed, during psychedelic medication therapy; first physician or other qualified health care professional, each hour	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
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	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
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	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
0823T	Transcatheter insertion of permanent single-chamber leadless pacemaker, right atrial, including imaging guidance and device evaluation when performed	Medical necessity review will be performed upon claims submission with supporting documentation	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
0825T	Transcatheter removal and replacement of permanent single-chamber, leadless pacemaker, right atrial, including imaging guidance and device evaluation, when performed	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	Submit history and physical, documentation of medical necessity and procedure report.
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	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	Submit history and physical, documentation of medical necessity and procedure report.
0857T	OPTO-ACOUSTIC IMAGING, BREAST, UNILATERAL, INCLUDING AXILLA WHEN PERFORMED, REAL[1]TIME WITH IMAGE DOCUMENTATION, AUGMENTATIVE ANALYSIS AND REPORT	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	Submit history and physical, documentation of medical necessity and procedure report.
0858T	Externally applied transcranial magnetic stimulation with concomitant measurement of evoked cortical potentials with automated report	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history and physical, documentation of medical necessity and procedure report; no review needed if member has a diagnosis of depression.
0859T	Noncontract near-infrared spectroscopy other than for screening for peripheral arterial disease, image acquisition, interpretation, and report; each additional anatomic site	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	Submit history and physical, documentation of medical necessity and procedure report.
0860T	Noncontact near-infrared spectroscopy for screening for peripheral arterial disease, including provocative maneuvers, image acquisition, interpretation & report, one or both lower extremities	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	Submit history and physical, documentation of medical necessity and procedure report.
0862T	Relocation of pulse generator for wireless cardiac stimulator for left ventricular pacing, including device interrogation and programming; battery component only	Medical necessity review will be performed upon claims submission with supporting documentation	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
0863T	Relocation of pulse generator for wireless cardiac stimulator for left ventricular pacing, including device interrogation and programming; transmitter component only	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	Submit history and physical, documentation of medical necessity and procedure report.
0864T	Low-intensity extracorporeal shock wave therapy involving corpus cavernosum, low energy	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	Submit history and physical, documentation of medical necessity and procedure report.
0865T	Quantitative (MRI) analysis of the brain with comparison to prior magnetic resonance study, including lesion identification, characterization & quantification with brain volumes	Prior Authorization Required	Medical Necessity	Submit history and physical and documentation of medical necessity, and procedure/imaging report
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)	Prior Authorization Required	Medical Necessity	Submit history and physical and documentation of medical necessity, and procedure/imaging report
0867T	Transperineal laser ablation of benign prostatic hyperplasia, including imaging guidance; prostate volume greater or equal to 50 mL	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	Submit history and physical, documentation of medical necessity and procedure report.
0868T	High-resolution gastric electrophysiology mapping with simultaneous patient-symptom profiling, with interpretation and report	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	Submit history and physical, documentation of medical necessity and procedure report.
0869T	Injection(s), bone-substitute material for bone and/or soft tissue hardware fixation augmentation, including intraoperative imaging guidance, when performed	Medical necessity review will be performed upon claims submission with supporting documentation	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
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	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	Submit history and physical, documentation of medical necessity and procedure report.
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	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	Submit history and physical, documentation of medical necessity and procedure report.
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	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	Submit history and physical, documentation of medical necessity and procedure report.
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	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	Submit history and physical, documentation of medical necessity and procedure report.
0875T	Programming of subcutaneously implanted peritoneal ascites pump system by physician or other qualified health care professional	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	Submit history and physical, documentation of medical necessity and procedure report.
0876T	Duplex scan of hemodialysis fistula, computer-aided, limited (volume flow, diameter, and depth, including only body of fistula)	Medical necessity review will be performed upon claims submission with supporting documentation	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
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	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	Submit history and physical, documentation of medical necessity and procedure report.
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	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	Submit history and physical, documentation of medical necessity and procedure report.
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	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	Submit history and physical, documentation of medical necessity and procedure report.
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	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	Submit history and physical, documentation of medical necessity and procedure report.
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	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	Submit history and physical, documentation of medical necessity and procedure report.

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Code List

Code	Description	Plan Review Requirement	Reviewed For	Records Request
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)	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	Submit history and physical, documentation of medical necessity and procedure report.
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)	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	Submit history and physical, documentation of medical necessity and procedure report.
0884T	Esophagoscopy, flexible, transoral, with initial transendoscopic mechanical dilation (eg, nondrug-coated balloon) followed by therapeutic drug delivery by drug-coated balloon catheter for esophageal stricture, including fluoroscopic guidance, when performed	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	Submit history and physical, documentation of medical necessity and procedure report.
0885T	Colonoscopy, flexible, with initial transendoscopic mechanical dilation (eg, nondrug-coated balloon) followed by therapeutic drug delivery by drug-coated balloon catheter for colonic stricture, including fluoroscopic guidance, when performed	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	Submit history and physical, documentation of medical necessity and procedure report.
0886T	Sigmoidoscopy, flexible, with initial transendoscopic mechanical dilation (eg, nondrug-coated balloon) followed by therapeutic drug delivery by drug-coated balloon catheter for colonic stricture, including fluoroscopic guidance, when performed	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	Submit history and physical, documentation of medical necessity and procedure report.

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0887T	End-tidal control of inhaled anesthetic agents and oxygen to assist anesthesia care delivery (List separately in addition to code for primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	Submit history and physical, documentation of medical necessity and procedure report.
0888T	Histotripsy (ie, non-thermal ablation via acoustic energy delivery) of malignant renal tissue, including imaging guidance	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	Submit history and physical, documentation of medical necessity and procedure report.
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	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	Submit history and physical, documentation of medical necessity and procedure report.
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	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	Submit history and physical, documentation of medical necessity and procedure report.
0891T	Accelerated, repetitive high-dose functional connectivity MRI-guided theta-burst stimulation, including neuronavigation, delivery and management, subsequent treatment day	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	Submit history and physical, documentation of medical necessity and procedure report.
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	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	Submit history and physical, documentation of medical necessity and procedure report.

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0893T	Noninvasive assessment of blood oxygenation, gas exchange efficiency, and cardiorespiratory status, with physician or other qualified health care professional interpretation and report	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	Submit history and physical, documentation of medical necessity and procedure report.
0894T	Cannulation of the liver allograft in preparation for connection to the normothermic perfusion device and decannulation of the liver allograft following normothermic perfusion	Prior Authorization Required	Medical Necessity	If transplant approval on record, date of transplant needed. If no transplant approval on record, submit history and physical, transplant evaluation and date of transplant. Note: For Blue Focus, medical necessity review will be performed upon claims submission with supporting documentation
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)	Prior Authorization Required	Medical Necessity	If transplant approval on record, date of transplant needed. If no transplant approval on record, submit history and physical, transplant evaluation and date of transplant. Note: For Blue Focus, medical necessity review will be performed upon claims submission with supporting documentation
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	Medical necessity review will be performed upon claims submission with supporting documentation	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
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	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	Submit history and physical, documentation of medical necessity and procedure report.
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)	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	Submit history and physical, documentation of medical necessity and procedure report.
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)	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	Submit history and physical, documentation of medical necessity and procedure report.

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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)	Prior Authorization Required	Investigative	History and physical, documentation of medical necessity, and procedure report
0936T	Photobiomodulation therapy of retina, single session	Medical necessity review will be performed upon claims submission with supporting documentation.	Potential Contract Exclusion	History and physical with operative/procedure report, as well as documentation to describe services
0948T	Interrogation device evaluation (remote), up to 90 days, cardiac contractility modulation system with interim analysis, review and report(s) by a physician or other qualified health care professional	Medical necessity review will be performed upon claims submission with supporting documentation	Investigative	Submit history and physical, documentation of medical necessity and procedure report.
0949T	Interrogation device evaluation (remote), up to 90 days, cardiac contractility modulation system, remote data acquisition(s), receipt of transmissions, technician review, technical support, and distribution of results	Medical necessity review will be performed upon claims submission with supporting documentation	Investigative	Submit history and physical, documentation of medical necessity and procedure report.
0950T	Ablation of benign prostate tissue, transrectal, with high intensity-focused ultrasound (HIFU), including ultrasound guidance	Medical necessity review will be performed upon claims submission with supporting documentation	Investigative	Submit history and physical, documentation of medical necessity and procedure report.

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0951T	Totally implantable active middle ear hearing implant; initial placement, including mastoidectomy, placement of and attachment to sound processor	Medical necessity review will be performed upon claims submission with supporting documentation	Investigative	Submit history and physical, documentation of medical necessity and procedure report.
0952T	Totally implantable active middle ear hearing implant; revision or replacement, with mastoidectomy and replacement of sound processor	Medical necessity review will be performed upon claims submission with supporting documentation	Investigative	Submit history and physical, documentation of medical necessity and procedure report.
0953T	Totally implantable active middle ear hearing implant; revision or replacement, without mastoidectomy and replacement of sound processor	Medical necessity review will be performed upon claims submission with supporting documentation	Investigative	Submit history and physical, documentation of medical necessity and procedure report.
0954T	Totally implantable active middle ear hearing implant; replacement of sound processor only, with attachment to existing transducers	Medical necessity review will be performed upon claims submission with supporting documentation	Investigative	Submit history and physical, documentation of medical necessity and procedure report.
0956T	Partial craniectomy, channel creation, and tunneling of electrode for sub-scalp implantation of an electrode array, receiver, and telemetry unit for continuous bilateral electroencephalography monitoring system, including imaging guidance	Medical necessity review will be performed upon claims submission with supporting documentation	Investigative	Submit history and physical, documentation of medical necessity and procedure report.
0957T	Revision of sub-scalp implanted electrode array, receiver, and telemetry unit for electrode, when required, including imaging guidance	Medical necessity review will be performed upon claims submission with supporting documentation	Investigative	Submit history and physical, documentation of medical necessity and procedure report.
0959T	Removal or replacement of magnet from coil assembly that is connected to continuous bilateral electroencephalography monitoring system, including imaging guidance	Medical necessity review will be performed upon claims submission with supporting documentation	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
0960T	Replacement of sub-scalp implanted electrode array, receiver, and telemetry unit with tunneling of electrode for continuous bilateral electroencephalography monitoring system, including imaging guidance	Medical necessity review will be performed upon claims submission with supporting documentation	Investigative	Submit history and physical, documentation of medical necessity and procedure report.
0963T	Anoscopy with directed submucosal injection of bulking agent into anal canal	Medical necessity review will be performed upon claims submission with supporting documentation	Investigative	Submit history and physical, documentation of medical necessity and procedure report.
0964T	Impression and custom preparation of jaw expansion oral prosthesis for obstructive sleep apnea, including initial adjustment; single arch, without mandibular advancement mechanism	Medical necessity review will be performed upon claims submission with supporting documentation	Investigative	Submit history and physical, documentation of medical necessity and procedure report.
0965T	Impression and custom preparation of jaw expansion oral prosthesis for obstructive sleep apnea, including initial adjustment; dual arch, with additional mandibular advancement, non-fixed hinge mechanism	Medical necessity review will be performed upon claims submission with supporting documentation	Investigative	Submit history and physical, documentation of medical necessity and procedure report.
0966T	Impression and custom preparation of jaw expansion oral prosthesis for obstructive sleep apnea, including initial adjustment; dual arch, with additional mandibular advancement, fixed hinge mechanism	Medical necessity review will be performed upon claims submission with supporting documentation	Investigative	Submit history and physical, documentation of medical necessity and procedure report.
0967T	Transanal insertion of endoluminal temporary colorectal anastomosis protection device, including vacuum anchoring component and flexible sheath connected to external vacuum source and monitoring system	Medical necessity review will be performed upon claims submission with supporting documentation	Investigative	Submit history and physical, documentation of medical necessity and procedure report.

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0968T	INSERTion or replacement of epicranial neurostimulator system, including electrode array and pulse generator, with connection to electrode array	Medical necessity review will be performed upon claims submission with supporting documentation	Investigative	Submit history and physical, documentation of medical necessity and procedure report.
0970T	Ablation, benign breast tumor (eg, fibroadenoma), percutaneous, laser, including imaging guidance when performed, each tumor	Medical necessity review will be performed upon claims submission with supporting documentation	Investigative	Submit history and physical, documentation of medical necessity and procedure report.
0971T	Ablation, malignant breast tumor(s), percutaneous, laser, including imaging guidance when performed, unilateral	Medical necessity review will be performed upon claims submission with supporting documentation	Investigative	Submit history and physical, documentation of medical necessity and procedure report.
0973T	Selective enzymatic debridement, partial-thickness and/or full-thickness burn eschar, requiring anesthesia (ie, general anesthesia, moderate sedation), including patient monitoring, trunk, arms, legs; first 100 sq cm	Medical necessity review will be performed upon claims submission with supporting documentation	Investigative	Submit history and physical, documentation of medical necessity and procedure report.
0974T	Selective enzymatic debridement, partial-thickness and/or full-thickness burn eschar, requiring anesthesia (ie, general anesthesia, moderate sedation), including patient monitoring, trunk, arms, legs; each additional 100 sq cm (List separately in addition to code for primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Investigative	Submit history and physical, documentation of medical necessity and procedure report.
0975T	Selective enzymatic debridement, partial-thickness and/or full-thickness burn eschar, requiring anesthesia (ie, general anesthesia, moderate sedation), including patient monitoring, scalp, neck, hands, feet, and/or multiple digits; first 100 sq cm	Medical necessity review will be performed upon claims submission with supporting documentation	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
0976T	Selective enzymatic debridement, partial-thickness and/or full-thickness burn eschar, requiring anesthesia (ie, general anesthesia, moderate sedation), including patient monitoring, scalp, neck, hands, feet, and/or multiple digits; each additional 100 sq cm (List separately in addition to code for primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Investigative	Submit history and physical, documentation of medical necessity and procedure report.
0977T	Upper gastrointestinal blood detection, sensor capsule, with interpretation and report	Medical necessity review will be performed upon claims submission with supporting documentation	Investigative	Submit history and physical, documentation of medical necessity and procedure report.
0978T	Submucosal cryolysis therapy; soft palate, base of tongue, and lingual tonsil	Medical necessity review will be performed upon claims submission with supporting documentation	Investigative	Submit history and physical, documentation of medical necessity and procedure report.
0979T	Submucosal cryolysis therapy; soft palate only	Medical necessity review will be performed upon claims submission with supporting documentation	Investigative	Submit history and physical, documentation of medical necessity and procedure report.
0980T	Submucosal cryolysis therapy; base of tongue and lingual tonsil only	Medical necessity review will be performed upon claims submission with supporting documentation	Investigative	Submit history and physical, documentation of medical necessity and procedure report.
0981T	Transcatheter implantation of wireless inferior vena cava sensor for long-term hemodynamic monitoring, including deployment of the sensor, radiological supervision and interpretation, right heart catheterization, and inferior vena cava venography, when performed	Medical necessity review will be performed upon claims submission with supporting documentation	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
0982T	Remote monitoring of implantable inferior vena cava pressure sensor, physiologic parameter(s) (eg, weight, blood pressure, pulse oximetry, respiratory flow rate), initial set-up and patient education on use of equipment	Medical necessity review will be performed upon claims submission with supporting documentation	Investigative	Submit history and physical, documentation of medical necessity and procedure report.
0983T	Remote monitoring of an implanted inferior vena cava sensor for up to 30 days, including at least weekly downloads of inferior vena cava area recordings, interpretation(s), trend analysis, and report(s) by a physician or other qualified health care professional	Medical necessity review will be performed upon claims submission with supporting documentation	Investigative	Submit history and physical, documentation of medical necessity and procedure report.
11055	Paring or cutting of benign hyperkeratotic lesion (eg, corn or callus); single lesion	Advance Benefit Determination (ABD) recommended	Potential Contract Exclusion	Documentation of medical necessity for the non-diabetic lesion removal/debridement; this is not applicable if member has a diagnosis of diabetes
11056	Paring or cutting of benign hyperkeratotic lesion (eg, corn or callus); 2 to 4 lesions	Advance Benefit Determination (ABD) recommended	Potential Contract Exclusion	Documentation of medical necessity for the non-diabetic lesion removal/debridement; this is not applicable if member has a diagnosis of diabetes
11057	Paring or cutting of benign hyperkeratotic lesion (eg, corn or callus); more than 4 lesions	Advance Benefit Determination (ABD) recommended	Potential Contract Exclusion	Documentation of medical necessity for the non-diabetic lesion removal/debridement; this is not applicable if member has a diagnosis of diabetes
11719	Trimming of nondystrophic nails, any number	Advance Benefit Determination (ABD) recommended	Potential Contract Exclusion	Documentation of medical necessity for the non-diabetic lesion removal/debridement; this is not applicable if member has a diagnosis of diabetes

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
11720	Debridement of nail(s) by any method(s); 1 to 5	Advance Benefit Determination (ABD) recommended	Potential Contract Exclusion	Documentation of medical necessity for the non-diabetic lesion removal/debridement; this is not applicable if member has a diagnosis of diabetes
11721	Debridement of nail(s) by any method(s); 6 or more	Advance Benefit Determination (ABD) recommended	Potential Contract Exclusion	Documentation of medical necessity for the non-diabetic lesion removal/debridement; this is not applicable if member has a diagnosis of diabetes
11920	Tattooing, intradermal introduction of insoluble opaque pigments to correct color defects of skin, including micropigmentation; 6.0 sq cm or less	Prior Authorization Required	Cosmetic	For gender affirming surgery: Submit history and physical, documentation of gender dysphoria and any hormone therapy, as well as written psychological assessment from a qualified mental health provider. For non-gender affirming surgery: Submit history and physical, pre-operative evaluation, including functional impairment and operative report. Medical necessity review will be performed upon claims submission with supporting documentation
11921	Tattooing, intradermal introduction of insoluble opaque pigments to correct color defects of skin, including micropigmentation; 6.1 to 20.0 sq cm	Prior Authorization Required	Cosmetic	For gender affirming surgery: Submit history and physical, documentation of gender dysphoria and any hormone therapy, as well as written psychological assessment from a qualified mental health provider. For non-gender affirming surgery: Submit history and physical, pre-operative evaluation, including functional impairment and operative report. No review required if member has a diagnosis of breast cancer.

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11922	Tattooing, intradermal introduction of insoluble opaque pigments to correct color defects of skin, including micropigmentation; each additional 20.0 sq cm, or part thereof (List separately in addition to code for primary procedure)	Prior Authorization Required	Cosmetic	For gender affirming surgery: Submit history and physical, documentation of gender dysphoria and any hormone therapy, as well as written psychological assessment from a qualified mental health provider. For non-gender affirming surgery: Submit history and physical, pre-operative evaluation, including functional impairment and operative report. Medical necessity review will be performed upon claims submission with supporting documentation
11950	Subcutaneous injection of filling material (eg, collagen); 1 cc or less	Advance Benefit Determination (ABD) recommended	Potential Contract Exclusion	For gender affirming surgery: Submit history and physical, documentation of gender dysphoria and any hormone therapy, as well as written psychological assessment from a qualified mental health provider. For non-gender affirming surgery: Submit history and physical, pre-operative evaluation, including functional impairment and operative report. Medical necessity review will be performed upon claims submission with supporting documentation

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11951	Subcutaneous injection of filling material (eg, collagen); 1.1 to 5.0 cc	Advance Benefit Determination (ABD) recommended	Potential Contract Exclusion	For gender affirming surgery: Submit history and physical, documentation of gender dysphoria and any hormone therapy, as well as written psychological assessment from a qualified mental health provider. For non-gender affirming surgery: Submit history and physical, pre-operative evaluation, including functional impairment and operative report. Medical necessity review will be performed upon claims submission with supporting documentation
11952	Subcutaneous injection of filling material (eg, collagen); 5.1 to 10.0 cc	Advance Benefit Determination (ABD) recommended	Potential Contract Exclusion	For gender affirming surgery: Submit history and physical, documentation of gender dysphoria and any hormone therapy, as well as written psychological assessment from a qualified mental health provider. For non-gender affirming surgery: Submit history and physical, pre-operative evaluation, including functional impairment and operative report. Medical necessity review will be performed upon claims submission with supporting documentation

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Code List

Code	Description	Plan Review Requirement	Reviewed For	Records Request
11954	Subcutaneous injection of filling material (eg, collagen); over 10.0 cc	Advance Benefit Determination (ABD) recommended	Potential Contract Exclusion	For gender affirming surgery: Submit history and physical, documentation of gender dysphoria and any hormone therapy, as well as written psychological assessment from a qualified mental health provider. For non-gender affirming surgery: Submit history and physical, pre-operative evaluation, including functional impairment and operative report. Medical necessity review will be performed upon claims submission with supporting documentation
11960	Insertion of tissue expander(s) for other than breast, including subsequent expansion	Advance Benefit Determination (ABD) recommended	Potential Contract Exclusion	History and physical, pre-operative evaluation, and procedure report
11970	Replacement of tissue expander with permanent implant	Advance Benefit Determination (ABD) recommended	Potential Contract Exclusion	For gender affirming surgery: Submit history and physical, documentation of gender dysphoria and any hormone therapy, as well as written psychological assessment from a qualified mental health provider. For non-gender affirming surgery: Submit history and physical, pre-operative evaluation, including functional impairment and operative report. Medical necessity review will be performed upon claims submission with supporting documentation
11971	Removal of tissue expander without insertion of implant	Prior Authorization Required	Cosmetic - Reconstructive	History and physical, pre-op evaluations, imaging reports, operative/procedure report, anesthesia report and documentation of medical necessity; no review needed if member has a diagnosis of breast cancer

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Code List

Code	Description	Plan Review Requirement	Reviewed For	Records Request
15011	Harvest of skin for skin cell suspension autograft; first 25 sq cm or less	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, operative report, and documentation supporting medical necessity
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)	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, operative report, and documentation supporting medical necessity
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	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, operative report, and documentation supporting medical necessity
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)	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, operative report, and documentation supporting medical necessity
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	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, operative report, and documentation supporting medical necessity
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)	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, operative report, and documentation supporting medical necessity

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Code List

Code	Description	Plan Review Requirement	Reviewed For	Records Request
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	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, operative report, and documentation supporting medical necessity
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)	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, operative report, and documentation supporting medical necessity
15769	Grafting of autologous soft tissue, other, harvested by direct excision (eg, fat, dermis, fascia)	Prior Authorization Required	Cosmetic	For gender affirming surgery: Submit history and physical, documentation of gender dysphoria and any hormone therapy, as well as written psychological assessment from a qualified mental health provider. For non-gender affirming surgery: Submit history and physical, pre-operative evaluation, including functional impairment and operative report. Medical necessity review will be performed upon claims submission with supporting documentation

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Code List

Code	Description	Plan Review Requirement	Reviewed For	Records Request
15771	Grafting of autologous fat harvested by liposuction technique to trunk, breasts, scalp, arms, and/or legs; 50 cc or less injectate	Prior Authorization Required	Cosmetic	For gender affirming surgery: Submit history and physical, documentation of gender dysphoria and any hormone therapy, as well as written psychological assessment from a qualified mental health provider. For non-gender affirming surgery: Submit history and physical, pre-operative evaluation, including functional impairment and operative report. Medical necessity review will be performed upon claims submission with supporting documentation
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)	Prior Authorization Required	Cosmetic	For gender affirming surgery: Submit history and physical, documentation of gender dysphoria and any hormone therapy, as well as written psychological assessment from a qualified mental health provider. For non-gender affirming surgery: Submit history and physical, pre-operative evaluation, including functional impairment and operative report. Medical necessity review will be performed upon claims submission with supporting documentation

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Code List

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	Prior Authorization Required	Cosmetic	For gender affirming surgery: Submit history and physical, documentation of gender dysphoria and any hormone therapy, as well as written psychological assessment from a qualified mental health provider. For non-gender affirming surgery: Submit history and physical, pre-operative evaluation, including functional impairment and operative report. Medical necessity review will be performed upon claims submission with supporting documentation
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)	Prior Authorization Required	Cosmetic	For gender affirming surgery: Submit history and physical, documentation of gender dysphoria and any hormone therapy, as well as written psychological assessment from a qualified mental health provider. For non-gender affirming surgery: Submit history and physical, pre-operative evaluation, including functional impairment and operative report. Medical necessity review will be performed upon claims submission with supporting documentation

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Code List

Code	Description	Plan Review Requirement	Reviewed For	Records Request
15775	Punch graft for hair transplant; 1 to 15 punch grafts	Advance Benefit Determination (ABD) recommended	Potential Contract Exclusion	For gender affirming surgery: Submit history and physical, documentation of gender dysphoria and any hormone therapy, as well as written psychological assessment from a qualified mental health provider. For non-gender affirming surgery: Submit history and physical, pre-operative evaluation, including functional impairment and operative report. Medical necessity review will be performed upon claims submission with supporting documentation
15776	Punch graft for hair transplant; more than 15 punch grafts	Advance Benefit Determination (ABD) recommended	Potential Contract Exclusion	For gender affirming surgery: Submit history and physical, documentation of gender dysphoria and any hormone therapy, as well as written psychological assessment from a qualified mental health provider. For non-gender affirming surgery: Submit history and physical, pre-operative evaluation, including functional impairment and operative report. Medical necessity review will be performed upon claims submission with supporting documentation
15777	Implantation of biologic implant (eg, acellular dermal matrix) for soft tissue reinforcement (eg, breast, trunk) (List separately in addition to code for primary procedure)	Prior Authorization Required	Cosmetic	History and physical, procedure/operative report and documentation that supports medical necessity of services

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Code List

Code	Description	Plan Review Requirement	Reviewed For	Records Request
15780	Dermabrasion; total face (eg, for acne scarring, fine wrinkling, rhytids, general keratosis)	Advance Benefit Determination (ABD) recommended	Potential Contract Exclusion	For gender affirming surgery: Submit history and physical, documentation of gender dysphoria and any hormone therapy, as well as written psychological assessment from a qualified mental health provider. For non-gender affirming surgery: Submit history and physical, pre-operative evaluation, including functional impairment and operative report. Medical necessity review will be performed upon claims submission with supporting documentation
15781	Dermabrasion; segmental, face	Advance Benefit Determination (ABD) recommended	Potential Contract Exclusion	For gender affirming surgery: Submit history and physical, documentation of gender dysphoria and any hormone therapy, as well as written psychological assessment from a qualified mental health provider. For non-gender affirming surgery: Submit history and physical, pre-operative evaluation, including functional impairment and operative report. Medical necessity review will be performed upon claims submission with supporting documentation

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
15782	Dermabrasion; regional, other than face	Advance Benefit Determination (ABD) recommended	Potential Contract Exclusion	For gender affirming surgery: Submit history and physical, documentation of gender dysphoria and any hormone therapy, as well as written psychological assessment from a qualified mental health provider. For non-gender affirming surgery: Submit history and physical, pre-operative evaluation, including functional impairment and operative report. Medical necessity review will be performed upon claims submission with supporting documentation
15783	Dermabrasion; superficial, any site (eg, tattoo removal)	Advance Benefit Determination (ABD) recommended	Potential Contract Exclusion	For gender affirming surgery: Submit history and physical, documentation of gender dysphoria and any hormone therapy, as well as written psychological assessment from a qualified mental health provider. For non-gender affirming surgery: Submit history and physical, pre-operative evaluation, including functional impairment and operative report. Medical necessity review will be performed upon claims submission with supporting documentation
15786	Abrasion; single lesion (eg, keratosis, scar)	Advance Benefit Determination (ABD) recommended	Potential Contract Exclusion	History and physical, and documentation of medical necessity including functional impairment, pre-operative evaluation, and operative report
15787	Abrasion; each additional 4 lesions or less (List separately in addition to code for primary procedure)	Advance Benefit Determination (ABD) recommended	Potential Contract Exclusion	History and physical, and documentation of medical necessity including functional impairment, pre-operative evaluation, and operative report

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Code List

Code	Description	Plan Review Requirement	Reviewed For	Records Request
15788	Chemical peel, facial; epidermal	Advance Benefit Determination (ABD) recommended	Potential Contract Exclusion	For gender affirming surgery: Submit history and physical, documentation of gender dysphoria and any hormone therapy, as well as written psychological assessment from a qualified mental health provider. For non-gender affirming surgery: Submit history and physical, pre-operative evaluation, including functional impairment and operative report. Medical necessity review will be performed upon claims submission with supporting documentation
15789	Chemical peel, facial; dermal	Advance Benefit Determination (ABD) recommended	Potential Contract Exclusion	For gender affirming surgery: Submit history and physical, documentation of gender dysphoria and any hormone therapy, as well as written psychological assessment from a qualified mental health provider. For non-gender affirming surgery: Submit history and physical, pre-operative evaluation, including functional impairment and operative report. Medical necessity review will be performed upon claims submission with supporting documentation

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Code List

Code	Description	Plan Review Requirement	Reviewed For	Records Request
15792	Chemical peel, nonfacial; epidermal	Advance Benefit Determination (ABD) recommended	Potential Contract Exclusion	For gender affirming surgery: Submit history and physical, documentation of gender dysphoria and any hormone therapy, as well as written psychological assessment from a qualified mental health provider. For non-gender affirming surgery: Submit history and physical, pre-operative evaluation, including functional impairment and operative report. Medical necessity review will be performed upon claims submission with supporting documentation
15793	Chemical peel, nonfacial; dermal	Advance Benefit Determination (ABD) recommended	Potential Contract Exclusion	For gender affirming surgery: Submit history and physical, documentation of gender dysphoria and any hormone therapy, as well as written psychological assessment from a qualified mental health provider. For non-gender affirming surgery: Submit history and physical, pre-operative evaluation, including functional impairment and operative report. Medical necessity review will be performed upon claims submission with supporting documentation
15820	Blepharoplasty, lower eyelid	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, documentation of medical necessity, and photographs
15821	Blepharoplasty, lower eyelid; with extensive herniated fat pad	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, documentation of medical necessity, and photographs
15822	Blepharoplasty, upper eyelid	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, documentation of medical necessity, and photographs
15823	Blepharoplasty, upper eyelid; with excessive skin weighting down lid	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, documentation of medical necessity, and photographs

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Code List

Code	Description	Plan Review Requirement	Reviewed For	Records Request
15824	Rhytidectomy; forehead	Advance Benefit Determination (ABD) recommended	Potential Contract Exclusion	For gender affirming surgery: Submit history and physical, documentation of gender dysphoria and any hormone therapy, as well as written psychological assessment from a qualified mental health provider. For non-gender affirming surgery: Submit history and physical, pre-operative evaluation, including functional impairment and operative report. Medical necessity review will be performed upon claims submission with supporting documentation
15825	Rhytidectomy; neck with platysmal tightening (platysmal flap, P-flap)	Advance Benefit Determination (ABD) recommended	Potential Contract Exclusion	For gender affirming surgery: Submit history and physical, documentation of gender dysphoria and any hormone therapy, as well as written psychological assessment from a qualified mental health provider. For non-gender affirming surgery: Submit history and physical, pre-operative evaluation, including functional impairment and operative report. Medical necessity review will be performed upon claims submission with supporting documentation

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
15826	Rhytidectomy; glabellar frown lines	Advance Benefit Determination (ABD) recommended	Potential Contract Exclusion	For gender affirming surgery: Submit history and physical, documentation of gender dysphoria and any hormone therapy, as well as written psychological assessment from a qualified mental health provider. For non-gender affirming surgery: Submit history and physical, pre-operative evaluation, including functional impairment and operative report. Medical necessity review will be performed upon claims submission with supporting documentation
15828	Rhytidectomy; cheek, chin, and neck	Advance Benefit Determination (ABD) recommended	Potential Contract Exclusion	For gender affirming surgery: Submit history and physical, documentation of gender dysphoria and any hormone therapy, as well as written psychological assessment from a qualified mental health provider. For non-gender affirming surgery: Submit history and physical, pre-operative evaluation, including functional impairment and operative report. Medical necessity review will be performed upon claims submission with supporting documentation

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
15829	Rhytidectomy; superficial musculoaponeurotic system (SMAS) flap	Advance Benefit Determination (ABD) recommended	Potential Contract Exclusion	For gender affirming surgery: Submit history and physical, documentation of gender dysphoria and any hormone therapy, as well as written psychological assessment from a qualified mental health provider. For non-gender affirming surgery: Submit history and physical, pre-operative evaluation, including functional impairment and operative report. Medical necessity review will be performed upon claims submission with supporting documentation
15830	Excision, excessive skin and subcutaneous tissue (includes lipectomy); abdomen, infraumbilical panniculectomy	Advance Benefit Determination (ABD) recommended	Potential Contract Exclusion	For gender affirming surgery: Submit history and physical, documentation of gender dysphoria and any hormone therapy, as well as written psychological assessment from a qualified mental health provider. For non-gender affirming surgery: Submit history and physical, pre-operative evaluation, including functional impairment and operative report. Medical necessity review will be performed upon claims submission with supporting documentation

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
15832	Excision, excessive skin and subcutaneous tissue (includes lipectomy); thigh	Advance Benefit Determination (ABD) recommended	Potential Contract Exclusion	For gender affirming surgery: Submit history and physical, documentation of gender dysphoria and any hormone therapy, as well as written psychological assessment from a qualified mental health provider. For non-gender affirming surgery: Submit history and physical, pre-operative evaluation, including functional impairment and operative report. Medical necessity review will be performed upon claims submission with supporting documentation
15833	Excision, excessive skin and subcutaneous tissue (includes lipectomy); leg	Advance Benefit Determination (ABD) recommended	Potential Contract Exclusion	For gender affirming surgery: Submit history and physical, documentation of gender dysphoria and any hormone therapy, as well as written psychological assessment from a qualified mental health provider. For non-gender affirming surgery: Submit history and physical, pre-operative evaluation, including functional impairment and operative report. Medical necessity review will be performed upon claims submission with supporting documentation

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
15834	Excision, excessive skin and subcutaneous tissue (includes lipectomy); hip	Advance Benefit Determination (ABD) recommended	Potential Contract Exclusion	For gender affirming surgery: Submit history and physical, documentation of gender dysphoria and any hormone therapy, as well as written psychological assessment from a qualified mental health provider. For non-gender affirming surgery: Submit history and physical, pre-operative evaluation, including functional impairment and operative report. Medical necessity review will be performed upon claims submission with supporting documentation
15835	Excision, excessive skin and subcutaneous tissue (includes lipectomy); buttock	Advance Benefit Determination (ABD) recommended	Potential Contract Exclusion	For gender affirming surgery: Submit history and physical, documentation of gender dysphoria and any hormone therapy, as well as written psychological assessment from a qualified mental health provider. For non-gender affirming surgery: Submit history and physical, pre-operative evaluation, including functional impairment and operative report. Medical necessity review will be performed upon claims submission with supporting documentation

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
15836	Excision, excessive skin and subcutaneous tissue (includes lipectomy); arm	Advance Benefit Determination (ABD) recommended	Potential Contract Exclusion	For gender affirming surgery: Submit history and physical, documentation of gender dysphoria and any hormone therapy, as well as written psychological assessment from a qualified mental health provider. For non-gender affirming surgery: Submit history and physical, pre-operative evaluation, including functional impairment and operative report. Medical necessity review will be performed upon claims submission with supporting documentation
15837	Excision, excessive skin and subcutaneous tissue (includes lipectomy); forearm or hand	Advance Benefit Determination (ABD) recommended	Potential Contract Exclusion	For gender affirming surgery: Submit history and physical, documentation of gender dysphoria and any hormone therapy, as well as written psychological assessment from a qualified mental health provider. For non-gender affirming surgery: Submit history and physical, pre-operative evaluation, including functional impairment and operative report. Medical necessity review will be performed upon claims submission with supporting documentation

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
15838	Excision, excessive skin and subcutaneous tissue (includes lipectomy); submental fat pad	Advance Benefit Determination (ABD) recommended	Potential Contract Exclusion	For gender affirming surgery: Submit history and physical, documentation of gender dysphoria and any hormone therapy, as well as written psychological assessment from a qualified mental health provider. For non-gender affirming surgery: Submit history and physical, pre-operative evaluation, including functional impairment and operative report. Medical necessity review will be performed upon claims submission with supporting documentation
15839	Excision, excessive skin and subcutaneous tissue (includes lipectomy); other area	Advance Benefit Determination (ABD) recommended	Potential Contract Exclusion	For gender affirming surgery: Submit history and physical, documentation of gender dysphoria and any hormone therapy, as well as written psychological assessment from a qualified mental health provider. For non-gender affirming surgery: Submit history and physical, pre-operative evaluation, including functional impairment and operative report. Medical necessity review will be performed upon claims submission with supporting documentation
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)	Advance Benefit Determination (ABD) recommended	Potential Contract Exclusion	Submit history and physical, pre-operative evaluation, including functional impairment, photos, and operative report

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
15876	Suction assisted lipectomy; head and neck	Advance Benefit Determination (ABD) recommended	Potential Contract Exclusion	For gender affirming surgery: Submit history and physical, documentation of gender dysphoria and any hormone therapy, as well as written psychological assessment from a qualified mental health provider. For non-gender affirming surgery: Submit history and physical, pre-operative evaluation, including functional impairment and operative report. Medical necessity review will be performed upon claims submission with supporting documentation
15877	Suction assisted lipectomy; trunk	Advance Benefit Determination (ABD) recommended	Potential Contract Exclusion	For gender affirming surgery: Submit history and physical, documentation of gender dysphoria and any hormone therapy, as well as written psychological assessment from a qualified mental health provider. For non-gender affirming surgery: Submit history and physical, pre-operative evaluation, including functional impairment and operative report. Medical necessity review will be performed upon claims submission with supporting documentation

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
15878	Suction assisted lipectomy; upper extremity	Advance Benefit Determination (ABD) recommended	Potential Contract Exclusion	For gender affirming surgery: Submit history and physical, documentation of gender dysphoria and any hormone therapy, as well as written psychological assessment from a qualified mental health provider. For non-gender affirming surgery: Submit history and physical, pre-operative evaluation, including functional impairment and operative report. Medical necessity review will be performed upon claims submission with supporting documentation
15879	Suction assisted lipectomy; lower extremity	Advance Benefit Determination (ABD) recommended	Potential Contract Exclusion	For gender affirming surgery: Submit history and physical, documentation of gender dysphoria and any hormone therapy, as well as written psychological assessment from a qualified mental health provider. For non-gender affirming surgery: Submit history and physical, pre-operative evaluation, including functional impairment and operative report. Medical necessity review will be performed upon claims submission with supporting documentation
15999	Unlisted procedure, excision pressure ulcer	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, including operative/procedure report and documentation that describes services
17106	Destruction of cutaneous vascular proliferative lesions (eg, laser technique); less than 10 sq cm	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, pre-operative evaluation, and procedure report
17107	Destruction of cutaneous vascular proliferative lesions (eg, laser technique); 10.0 to 50.0 sq cm	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, pre-operative evaluation, and procedure report

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17108	Destruction of cutaneous vascular proliferative lesions (eg, laser technique); over 50.0 sq cm	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, pre-operative evaluation, and procedure report
17360	Chemical exfoliation for acne (eg, acne paste, acid)	Advance Benefit Determination (ABD) recommended	Potential Contract Exclusion	History and physical, and documentation of medical necessity, including previous treatments for condition
17380	Electrolysis epilation, each 30 minutes	Prior Authorization Required	Gender Affirming Surgery	For gender affirming surgery: Submit history and physical, chart notes from the session(s) in which the diagnosis of gender dysphoria was determined, documentation of continuous hormone therapy, and written psychological assessment from a qualified mental health professional Note: Service may also be non-covered
17999	Unlisted procedure, skin, mucous membrane and subcutaneous tissue	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, including operative/procedure report and documentation that describes services
19105	Ablation, cryosurgical, of fibroadenoma, including ultrasound guidance, each fibroadenoma	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, pre-operative evaluation, and operative report
19300	Mastectomy for gynecomastia	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, pre-operative evaluation, office visit(s), pathology report, operative report, medication records, and length of time condition present

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19303	Mastectomy, simple, complete	Prior Authorization Required	Gender Affirming Surgery	No review needed if diagnosis is related to breast cancer.For non-gender affirming surgery: Submit history and physical, and documentation of medical necessity.For gender affirming surgery: Submit history and physical, chart notes from the session(s) in which the diagnosis of gender dysphoria was determined, documentation of continuous hormone therapy, and written psychological assessment from a qualified mental health professional
19316	Mastopexy	Prior Authorization Required	Cosmetic	For gender affirming surgery: Submit history and physical, documentation of gender dysphoria and any hormone therapy, as well as written psychological assessment from a qualified mental health provider. For non-gender affirming surgery: Submit history and physical, pre-operative evaluation, including functional impairment and operative report. Medical necessity review will be performed upon claims submission with supporting documentation

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
19318	Breast reduction	Prior Authorization Required	Cosmetic	For gender affirming surgery: Submit history and physical, documentation of gender dysphoria and any hormone therapy, as well as written psychological assessment from a qualified mental health provider. For non-gender affirming surgery: Submit history and physical, pre-operative evaluation, including functional impairment and operative report. Medical necessity review will be performed upon claims submission with supporting documentation
19325	Breast augmentation with implant	Prior Authorization Required	Cosmetic	For gender affirming surgery: Submit history and physical, documentation of gender dysphoria and any hormone therapy, as well as written psychological assessment from a qualified mental health provider. For non-gender affirming surgery: Submit history and physical, pre-operative evaluation, including functional impairment and operative report. Medical necessity review will be performed upon claims submission with supporting documentation
19328	Removal of intact breast implant	Prior Authorization Required	Cosmetic	History and physical, pre-operative evaluation, including functional impairment, and operative report
19330	Removal of ruptured breast implant, including implant contents (eg, saline, silicone gel)	Prior Authorization Required	Cosmetic	History and physical, pre-operative evaluation, including functional impairment, and operative report
19340	Insertion of breast implant on same day of mastectomy (ie, immediate)	Prior Authorization Required	Cosmetic	History and physical, pre-operative evaluation, including functional impairment, and operative report

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19342	Insertion or replacement of breast implant on separate day from mastectomy	Prior Authorization Required	Cosmetic	History and physical, pre-operative evaluation, including functional impairment, and operative report
19350	Nipple/areola reconstruction	Prior Authorization Required	Gender Affirming Surgery	For gender affirming surgery: Submit history and physical, documentation of gender dysphoria and any hormone therapy, as well as written psychological assessment from a qualified mental health provider. For non-gender affirming surgery: Submit history and physical, pre-operative evaluation, including functional impairment and operative report. Medical necessity review will be performed upon claims submission with supporting documentation
19355	Correction of inverted nipples	Prior Authorization Required	Cosmetic	History and physical, pre-operative evaluation, including functional impairment, and operative report
19357	Tissue expander placement in breast reconstruction, including subsequent expansion(s)	Prior Authorization Required	Cosmetic	For gender affirming surgery: Submit history and physical, documentation of gender dysphoria and any hormone therapy, as well as written psychological assessment from a qualified mental health provider. For non-gender affirming surgery: Submit history and physical, pre-operative evaluation, including functional impairment and operative report. Medical necessity review will be performed upon claims submission with supporting documentation
19361	BREAST RECONSTRUCT W/LATISSIMUS DORSI FLAP W/ W/OUT IMPLANT	Prior Authorization Required	Cosmetic	History and physical, pre-operative evaluation, including functional impairment, and operative report

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19364	BREAST RECONSTRUCTION W/ FREE FLAP	Prior Authorization Required	Cosmetic	History and physical, pre-operative evaluation, including functional impairment, and operative report
19367	Breast reconstruction; with single-pedicled transverse rectus abdominis myocutaneous (TRAM) flap	Prior Authorization Required	Cosmetic	History and physical, pre-operative evaluation, including functional impairment, and operative report
19368	Breast reconstruction; with single-pedicled transverse rectus abdominis myocutaneous (TRAM) flap, requiring separate microvascular anastomosis (supercharging)	Prior Authorization Required	Cosmetic	History and physical, pre-operative evaluation, including functional impairment, and operative report
19369	Breast reconstruction; with bipedicled transverse rectus abdominis myocutaneous (TRAM) flap	Prior Authorization Required	Cosmetic	History and physical, pre-operative evaluation, including functional impairment, and operative report
19370	Revision of peri-implant capsule, breast, including capsulotomy, capsulorrhaphy, and/or partial capsulectomy	Advance Benefit Determination (ABD) recommended	Potential Contract Exclusion	For non-breast cancer diagnosis: Submit history and physical, pre-operative evaluation, and documentation of medical necessity, including functional impairment and operative report; if diagnosis is related to breast cancer, allow service
19371	Peri-implant capsulectomy, breast, complete, including removal of all intracapsular contents	Advance Benefit Determination (ABD) recommended	Potential Contract Exclusion	For non-breast cancer diagnosis: Submit history and physical, pre-operative evaluation, and documentation of medical necessity, including functional impairment and operative report; if diagnosis is related to breast cancer, allow service
19380	Revision of reconstructed breast (eg, significant removal of tissue, re-advancement and/or re-inset of flaps in autologous reconstruction or significant capsular revision combined with soft tissue excision in implant-based reconstruction)	Prior Authorization Required	Cosmetic	History and physical, pre-operative evaluation(s), including functional impairment, and operative report. No review needed if the member has a breast cancer diagnosis.

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19396	PREPARATION OF MOULAGE FOR CUSTOM BREAST IMPLANT	Prior Authorization Required	Cosmetic	History and physical, pre-operative evaluation, including functional impairment, and operative report
19499	Unlisted procedure breast	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, including operative/procedure report and documentation that describes services
20560	Needle insertion(s) without injection(s); 1 or 2 muscle(s)	Advance Benefit Determination (ABD) recommended	Investigative	Submit procedure/testing report
20561	Needle insertion(s) without injection(s); 3 or more muscles	Advance Benefit Determination (ABD) recommended	Investigative	Submit procedure/testing report
20650	INSERTion of wire or pin with application of skeletal traction, including removal (separate procedure)	Prior Authorization Required	Medical Necessity	History and physical, pre-operative evaluation, including functional impairment, and operative report
20662	Application of halo, including removal; pelvic	Prior Authorization Required	Medical Necessity	History and physical, pre-operative evaluation, including functional impairment, and operative report
20663	Application of halo, including removal; femoral	Prior Authorization Required	Medical Necessity	History and physical, pre-operative evaluation, including functional impairment, and operative report
20665	Removal of tongs or halo applied by another individual	Prior Authorization Required	Medical Necessity	History and physical, pre-operative evaluation, including functional impairment, and operative report
20670	Removal of implant; superficial (eg, buried wire, pin or rod) (separate procedure)	Prior Authorization Required	Medical Necessity	History and physical, pre-operative evaluation, including functional impairment, and operative report
20680	Removal of implant; deep (e.g., buried wire, pin, screw, metal band, nail, rod or plate)	Prior Authorization Required	Medical Necessity	History and physical, pre-operative evaluation, including functional impairment, and operative report
20690	Application of a uniplane (pins or wires in 1 plane), unilateral, external fixation system	Prior Authorization Required	Medical Necessity	History and physical, pre-operative evaluation, including functional impairment, and operative report
20692	application of pins Ilizarov	Prior Authorization Required	Medical Necessity	History and physical, pre-operative evaluation, including functional impairment, and operative report

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20693	Adjustment or revision of external fixation system requiring anesthesia (eg, new pin[s] or wire[s] and/or new ring[s] or bar[s])	Prior Authorization Required	Medical Necessity	History and physical, pre-operative evaluation, including functional impairment, and operative report
20694	Removal, under anesthesia, of external fixation system	Prior Authorization Required	Medical Necessity	History and physical, pre-operative evaluation, including functional impairment, and operative report
20696	Application of multiplane (pins or wires in more than 1 plane), unilateral, external fixation with stereotactic computer-assisted adjustment (eg, spatial frame), including imaging, exchange (ie, removal & replacement of strut,each)	Prior Authorization Required	Medical Necessity	History and physical, pre-operative evaluation, including functional impairment, and operative report
20697	Application of multiplane (pins or wires in more than 1 plane), unilateral, external fixation with stereotactic computer-assisted adjustment (eg, spatial frame), including imaging; exchange (ie, removal and replacement) of strut, each	Prior Authorization Required	Medical Necessity	History and physical, pre-operative evaluation, including functional impairment, and operative report
20900	Bone graft, any donor area; minor or small (eg, dowel or button)	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, conservative measures, operative report, and anesthesia report
20902	Bone graft, any donor area; major or large	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, conservative measures, operative report, and anesthesia report
20920	Fascia lata graft; by stripper	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, conservative measures, operative report, and anesthesia report

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20922	Fascia lata graft; by incision and area exposure, complex or sheet	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, conservative measures, operative report, and anesthesia report
20924	Tendon graft, from a distance (eg, palmaris, toe extensor, plantaris)	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, conservative measures, operative report, and anesthesia report
20930	Allograft, morselized, or placement of osteopromotive material, for spine surgery only (List separately in addition to code for primary procedure)	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, conservative measures, operative report, and anesthesia report
20931	Allograft, structural, for spine surgery only (List separately in addition to code for primary procedure)	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, conservative measures, operative report, and anesthesia report
20936	Autograft for spine surgery only (includes harvesting the graft); local (eg, ribs, spinous process, or laminar fragments) obtained from same incision (List separately in addition to code for primary procedure)	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, conservative measures, operative report, and anesthesia report
20937	Autograft for spine surgery only (includes harvesting the graft); morselized (through separate skin or fascial incision) (List separately in addition to code for primary procedure)	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, conservative measures, operative report, and anesthesia report
20938	Autograft for spine surgery only (includes harvesting the graft); structural, bicortical or tricortical (through separate skin or fascial incision) (List separately in addition to code for primary procedure)	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, conservative measures, operative report, and anesthesia report

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20939	Bone marrow aspiration for bone grafting, spine surgery only, through separate skin or fascial incision (List separately in addition to code for primary procedure)	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, conservative measures, operative report, and anesthesia report.
20955	Bone graft with microvascular anastomosis; fibula	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, conservative measures, operative report, and anesthesia report
20956	Bone graft with microvascular anastomosis; iliac crest	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, conservative measures, operative report, and anesthesia report
20962	Bone graft with microvascular anastomosis; other than fibula, iliac crest, or metatarsal	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, conservative measures, operative report, and anesthesia report
20970	Free osteocutaneous flap with microvascular anastomosis; iliac crest	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, conservative measures, operative report, and anesthesia report
20974	Electrical stimulation to aid bone healing; noninvasive (nonoperative)	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, including location of the fracture and any co-morbidities. If request is for a non-union fracture, include date of fracture, serial radiographs detailing any history of healing, and documentation of adequacy of immobilization

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20975	Electrical stimulation to aid bone healing; invasive (operative)	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, including location of the fracture and any co-morbidities. If request is for a non-union fracture, include date of fracture, serial radiographs detailing any history of healing, and documentation of adequacy of immobilization. Medical necessity review will be performed upon claims submission with supporting documentation
20979	Low intensity ultrasound stimulation to aid bone healing, noninvasive (nonoperative)	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, including co-morbidities and date of fracture, fracture location, and serial radiographs showing nonhealing and fracture gap. Medical necessity review will be performed upon claims submission with supporting documentation
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	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, documentation of medical necessity, and procedure 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	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
20985	Computer-assisted surgical navigational procedure for musculoskeletal procedures; image-less (List separately in addition to code for primary procedure)	Prior Authorization Required	Investigative	Submit procedure/testing report

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20999	Unlisted procedure, musculoskeletal system, general	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical with operative/procedure report, as well as documentation to describe services
21010	Arthrotomy, temporomandibular joint	Prior Authorization Required	Medical Necessity	History and physical, pre-op evaluations, and documentation of medical necessity from dental provider
21026	Excision of bone (eg, for osteomyelitis or bone abscess); facial bone(s)	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, operative report and anesthesia report
21030	Excision of benign tumor or cyst of maxilla or zygoma by enucleation and curettage	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, operative report and anesthesia report
21031	Excision of torus mandibularis	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, operative report and anesthesia report
21032	Excision of maxillary torus palatinus	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, operative report and anesthesia report
21034	Excision of malignant tumor of maxilla or zygoma	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, operative report and anesthesia report
21040	Excision of benign tumor or cyst of mandible, by enucleation and/or curettage	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, operative report and anesthesia report
21044	Excision of malignant tumor of mandible	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, operative report and anesthesia report

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21045	Excision of malignant tumor of mandible; radical resection	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, operative report and anesthesia report
21046	Excision of benign tumor or cyst of mandible; requiring intra-oral osteotomy (eg, locally aggressive or destructive lesion(s))	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, operative report and anesthesia report
21047	requiring extra-oral osteotomy and partial mandibulectomy (eg, locally aggressive or destructive lesion(s))	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, operative report and anesthesia report
21048	Excision of benign tumor or cyst of maxilla; requiring intra-oral osteotomy (eg, locally aggressive or destructive lesion(s))	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, operative report and anesthesia report
21049	requiring extra-oral osteotomy and partial mandibulectomy (eg, locally aggressive or destructive lesion(s))	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, operative report and anesthesia report
21050	Condylectomy, temporomandibular joint (separate procedure)	Prior Authorization Required	Medical Necessity	History and physical, pre-op evaluations, and documentation of medical necessity from dental provider
21060	Meniscectomy, partial or complete, temporomandibular joint (separate procedure)	Prior Authorization Required	Medical Necessity	History and physical, pre-op evaluations, and documentation of medical necessity from dental provider
21070	Coronoidectomy (separate procedure)	Prior Authorization Required	Medical Necessity	History and physical, pre-op evaluations, and documentation of medical necessity from dental provider
21073	Manipulation of temporomandibular joint(s) (TMJ), therapeutic, requiring an anesthesia service (ie, general or monitored anesthesia care)	Prior Authorization Required	Medical Necessity	History and physical, pre-op evaluations, and documentation of medical necessity from dental provider
21085	Impression and custom preparation; oral surgical splint	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit type of appliance and diagnosis along with chart notes pertaining to applicable diagnosis. Dental review fax is 425-918-5956

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21088	Impression and custom preparation; facial prosthesis	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit type of appliance and diagnosis along with chart notes pertaining to applicable diagnosis. Dental review fax is 425-918-5956
21089	Unlisted maxillofacial prosthetic procedure	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit type of appliance and diagnosis along with chart notes pertaining to applicable diagnosis. Dental review fax is 425-918-5956
21110	Application of interdental fixation device for conditions other than fracture or dislocation, includes removal	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
21116	Injection procedure for temporomandibular joint arthrography	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, operative report and anesthesia report
21120	Genioplasty; augmentation (autograft, allograft, prosthetic material)	Prior Authorization Required	Cosmetic	For dental review: Submit history and physical, and imaging/photos, and age and history of orthodontic treatment; dental review fax is 425-918-5956. For gender affirming surgery: Submit history and physical, documentation of gender dysphoria and any hormone therapy, as well as written psychological assessment from a qualified mental health provider. For non-gender affirming surgery: Medical necessity review will be performed upon claims submission with supporting documentation

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21121	Genioplasty; sliding osteotomy, single piece	Prior Authorization Required	Cosmetic	For dental review: Submit history and physical, and imaging/photos, and age and history of orthodontic treatment; dental review fax is 425-918-5956. For gender affirming surgery: Submit history and physical, documentation of gender dysphoria and any hormone therapy, as well as written psychological assessment from a qualified mental health provider. For non-gender affirming surgery: Medical necessity review will be performed upon claims submission with supporting documentation
21122	Genioplasty; sliding osteotomies, 2 or more osteotomies (eg, wedge excision or bone wedge reversal for asymmetrical chin)	Prior Authorization Required	Cosmetic	For dental review: Submit history and physical, and imaging/photos, and age and history of orthodontic treatment; dental review fax is 425-918-5956. For gender affirming surgery: Submit history and physical, documentation of gender dysphoria and any hormone therapy, as well as written psychological assessment from a qualified mental health provider. For non-gender affirming surgery: Medical necessity review will be performed upon claims submission with supporting documentation

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21123	Genioplasty; sliding, augmentation with interpositional bone grafts (includes obtaining autografts)	Prior Authorization Required	Cosmetic	For dental review: Submit history and physical, and imaging/photos, and age and history of orthodontic treatment; dental review fax is 425-918-5956. For gender affirming surgery: Submit history and physical, documentation of gender dysphoria and any hormone therapy, as well as written psychological assessment from a qualified mental health provider. For non-gender affirming surgery: Medical necessity review will be performed upon claims submission with supporting documentation
21125	Augmentation, mandibular body or angle; prosthetic material	Prior Authorization Required	Cosmetic	For dental review: Submit history and physical, and imaging/photos, and age and history of orthodontic treatment; dental review fax is 425-918-5956. For gender affirming surgery: Submit history and physical, documentation of gender dysphoria and any hormone therapy, as well as written psychological assessment from a qualified mental health provider. For non-gender affirming surgery: Medical necessity review will be performed upon claims submission with supporting documentation

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21127	Augmentation, mandibular body or angle; with bone graft, onlay or interpositional (includes obtaining autograft)	Prior Authorization Required	Cosmetic	For dental review: Submit history and physical, and imaging/photos, and age and history of orthodontic treatment; dental review fax is 425-918-5956. For gender affirming surgery: Submit history and physical, documentation of gender dysphoria and any hormone therapy, as well as written psychological assessment from a qualified mental health provider. For non-gender affirming surgery: Medical necessity review will be performed upon claims submission with supporting documentation
21137	Reduction forehead; contouring only	Prior Authorization Required	Cosmetic	For dental review: Submit history and physical, and imaging/photos, and age and history of orthodontic treatment; dental review fax is 425-918-5956. For gender affirming surgery: Submit history and physical, documentation of gender dysphoria and any hormone therapy, as well as written psychological assessment from a qualified mental health provider. For non-gender affirming surgery: Medical necessity review will be performed upon claims submission with supporting documentation

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21138	Reduction forehead; contouring and application of prosthetic material or bone graft (includes obtaining autograft)	Prior Authorization Required	Cosmetic	For gender affirming surgery: Submit history and physical, documentation of gender dysphoria and any hormone therapy, as well as written psychological assessment from a qualified mental health provider. For non-gender affirming surgery: Submit history and physical, pre-operative evaluation, including functional impairment and operative report. Medical necessity review will be performed upon claims submission with supporting documentation
21139	Reduction forehead; contouring and setback of anterior frontal sinus wall	Prior Authorization Required	Cosmetic	For gender affirming surgery: Submit history and physical, documentation of gender dysphoria and any hormone therapy, as well as written psychological assessment from a qualified mental health provider. For non-gender affirming surgery: Submit history and physical, pre-operative evaluation, including functional impairment and operative report. Medical necessity review will be performed upon claims submission with supporting documentation
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	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, treatment history, operative report and anesthesia report
21142	Reconstruction midface, LeFort I; 2 pieces, segment movement in any direction, without bone graft	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, treatment history, operative report and anesthesia report

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
21143	Reconstruction midface, LeFort I; 3 or more pieces, segment movement in any direction, without bone graft	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, treatment history, operative report and anesthesia report
21145	Reconstruction midface, LeFort I; single piece, segment movement in any direction, requiring bone grafts (includes obtaining autografts)	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, treatment history, operative report and anesthesia report
21146	Reconstruction midface, LeFort I; 2 pieces, segment movement in any direction, requiring bone grafts (includes obtaining autografts) (eg, ungrafted unilateral alveolar cleft)	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, treatment history, operative report and anesthesia report
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)	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, treatment history, operative report and anesthesia report
21150	Reconstruction midface, LeFort II; anterior intrusion (eg, Treacher-Collins Syndrome)	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, treatment history, operative report and anesthesia report
21151	Reconstruction midface, LeFort II; any direction, requiring bone grafts (includes obtaining autografts)	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, treatment history, operative report and anesthesia report
21154	Reconstruction midface, LeFort III (extracranial), any type, requiring bone grafts (includes obtaining autografts); without LeFort I	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, treatment history, operative report and anesthesia report

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
21155	Reconstruction midface, LeFort III (extracranial), any type, requiring bone grafts (includes obtaining autografts); with LeFort I	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, treatment history, operative report and anesthesia report
21159	Reconstruction midface, LeFort III (extra and intracranial) with forehead advancement (eg, mono bloc), requiring bone grafts (includes obtaining autografts); without LeFort I	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, treatment history, operative report and anesthesia report
21160	Reconstruction midface, LeFort III (extra and intracranial) with forehead advancement (eg, mono bloc), requiring bone grafts (includes obtaining autografts); with LeFort I	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, treatment history, operative report and anesthesia report
21172	Reconstruction superior-lateral orbital rim and lower forehead, advancement or alteration, with or without grafts (includes obtaining autografts)	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, treatment history, operative report and anesthesia report
21175	Reconstruction, bifrontal, superior-lateral orbital rims and lower forehead, advancement or alteration (eg, plagiocephaly, trigonocephaly, brachycephaly), with or without grafts (includes obtaining autografts)	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, treatment history, operative report and anesthesia report
21179	Reconstruction, entire or majority of forehead and/or supraorbital rims; with grafts (allograft or prosthetic material)	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, treatment history, operative report and anesthesia report
21180	Reconstruction, entire or majority of forehead and/or supraorbital rims; with autograft (includes obtaining grafts)	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, treatment history, operative report and anesthesia report

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Code List

Code	Description	Plan Review Requirement	Reviewed For	Records Request
21181	Reconstruction by contouring of benign tumor of cranial bones (eg, fibrous dysplasia), extracranial	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, treatment history, operative report and anesthesia report
21182	Reconstruction of orbital walls, rims, forehead, nasoethmoid complex following intra- and extracranial excision of benign tumor of cranial bone (eg, fibrous dysplasia), with multiple autografts (includes obtaining grafts); total area of bone grafting less than 40 sq cm	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, treatment history, operative report and anesthesia report
21183	Reconstruction of orbital walls, rims, forehead, nasoethmoid complex following intra- and extracranial excision of benign tumor of cranial bone (eg, fibrous dysplasia), with multiple autografts (includes obtaining grafts); total area of bone grafting greater than 40 sq cm but less than 80 sq cm	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, treatment history, operative report and anesthesia report
21184	Reconstruction of orbital walls, rims, forehead, nasoethmoid complex following intra- and extracranial excision of benign tumor of cranial bone (eg, fibrous dysplasia), with multiple autografts (includes obtaining grafts); total area of bone grafting greater than 80 sq cm	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, treatment history, operative report and anesthesia report

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
21188	Reconstruction midface, osteotomies (other than LeFort type) and bone grafts (includes obtaining autografts)	Prior Authorization Required	Medical Necessity	For gender affirming surgery: Submit history and physical, documentation of gender dysphoria and any hormone therapy, as well as written psychological assessment from a qualified mental health provider. For non-gender affirming surgery: Submit history and physical, pre-operative evaluation, including functional impairment and operative report. Medical necessity review will be performed upon claims submission with supporting documentation
21193	Reconstruction of mandibular rami, horizontal, vertical, C, or L osteotomy; without bone graft	Prior Authorization Required	Medical Necessity	For dental review: Submit history and physical, pre-op evaluations, and documentation of medical necessity from a dental provider. Dental review fax is 425-918-5956.For gender affirming surgery: Submit history and physical, chart notes from the session(s) in which the diagnosis of gender dysphoria was determined, documentation of continuous hormone therapy, and written psychological assessment from a qualified mental health professional

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
21194	Reconstruction of mandibular rami, horizontal, vertical, C, or L osteotomy; with bone graft (includes obtaining graft)	Prior Authorization Required	Medical Necessity	For dental review: Submit history and physical, pre-op evaluations, and documentation of medical necessity from a dental provider. Dental review fax is 425-918-5956.For gender affirming surgery: Submit history and physical, chart notes from the session(s) in which the diagnosis of gender dysphoria was determined, documentation of continuous hormone therapy, and written psychological assessment from a qualified mental health professional
21195	Reconstruction of mandibular rami and/or body, sagittal split; without internal rigid fixation	Prior Authorization Required	Medical Necessity	For dental review: Submit history and physical, pre-op evaluations, and documentation of medical necessity from a dental provider. Dental review fax is 425-918-5956.For gender affirming surgery: Submit history and physical, chart notes from the session(s) in which the diagnosis of gender dysphoria was determined, documentation of continuous hormone therapy, and written psychological assessment from a qualified mental health professional

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21196	Reconstruction of mandibular rami and/or body, sagittal split; with internal rigid fixation	Prior Authorization Required	Medical Necessity	For dental review: Submit history and physical, pre-op evaluations, and documentation of medical necessity from a dental provider. Dental review fax is 425-918-5956.For gender affirming surgery: Submit history and physical, chart notes from the session(s) in which the diagnosis of gender dysphoria was determined, documentation of continuous hormone therapy, and written psychological assessment from a qualified mental health professional
21198	Osteotomy, mandible, segmental;	Prior Authorization Required	Medical Necessity	For dental review: Submit history and physical, pre-op evaluations, and documentation of medical necessity from a dental provider. Dental review fax is 425-918-5956.For gender affirming surgery: Submit history and physical, chart notes from the session(s) in which the diagnosis of gender dysphoria was determined, documentation of continuous hormone therapy, and written psychological assessment from a qualified mental health professional

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
21199	Osteotomy, mandible, segmental; with genioglossus advancement	Prior Authorization Required	Medical Necessity	For dental review: Submit history and physical, pre-op evaluations, and documentation of medical necessity from a dental provider. Dental review fax is 425-918-5956.For gender affirming surgery: Submit history and physical, chart notes from the session(s) in which the diagnosis of gender dysphoria was determined, documentation of continuous hormone therapy, and written psychological assessment from a qualified mental health professional
21206	Osteotomy, maxilla, segmental (eg, Wassmund or Schuchard)	Prior Authorization Required	Medical Necessity	For dental review: Submit history and physical, pre-op evaluations, and documentation of medical necessity from a dental provider. Dental review fax is 425-918-5956.For gender affirming surgery: Submit history and physical, chart notes from the session(s) in which the diagnosis of gender dysphoria was determined, documentation of continuous hormone therapy, and written psychological assessment from a qualified mental health professional

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
21208	Osteoplasty, facial bones; augmentation (autograft, allograft, or prosthetic implant)	Prior Authorization Required	Medical Necessity	For dental review: Submit history and physical, and imaging/photos, and age and history of orthodontic treatment; dental review fax is 425-918-5956. For gender affirming surgery: Submit history and physical, documentation of gender dysphoria and any hormone therapy, as well as written psychological assessment from a qualified mental health provider. For non-gender affirming surgery: Medical necessity review will be performed upon claims submission with supporting documentation
21209	Osteoplasty, facial bones; reduction	Prior Authorization Required	Medical Necessity	For dental review: Submit history and physical, and imaging/photos, and age and history of orthodontic treatment; dental review fax is 425-918-5956. For gender affirming surgery: Submit history and physical, documentation of gender dysphoria and any hormone therapy, as well as written psychological assessment from a qualified mental health provider. For non-gender affirming surgery: Medical necessity review will be performed upon claims submission with supporting documentation

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Code List

Code	Description	Plan Review Requirement	Reviewed For	Records Request
21210	Graft, bone; nasal, maxillary or malar areas (includes obtaining graft)	Prior Authorization Required	Medical Necessity	For dental review: Submit history and physical, pre-op evaluations, and documentation of medical necessity from a dental provider. Dental review fax is 425-918-5956.For gender affirming surgery: Submit history and physical, chart notes from the session(s) in which the diagnosis of gender dysphoria was determined, documentation of continuous hormone therapy, and written psychological assessment from a qualified mental health professional
21215	Graft, bone; mandible (includes obtaining graft)	Prior Authorization Required	Medical Necessity	For dental review: Submit history and physical, pre-op evaluations, and documentation of medical necessity from a dental provider. Dental review fax is 425-918-5956.For gender affirming surgery: Submit history and physical, chart notes from the session(s) in which the diagnosis of gender dysphoria was determined, documentation of continuous hormone therapy, and written psychological assessment from a qualified mental health professional
21230	Graft; rib cartilage, autogenous, to face, chin, nose or ear (includes obtaining graft)	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, operative report and anesthesia report
21235	Graft; ear cartilage, autogenous, to nose or ear (includes obtaining graft)	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, operative report and anesthesia report

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Code List

Code	Description	Plan Review Requirement	Reviewed For	Records Request
21240	Arthroplasty, temporomandibular joint, with or without autograft (includes obtaining graft)	Prior Authorization Required	Medical Necessity	For dental review: Submit history and physical, pre-op evaluations, and documentation of medical necessity from a dental provider. Dental review fax is 425-918-5956.For gender affirming surgery: Submit history and physical, chart notes from the session(s) in which the diagnosis of gender dysphoria was determined, documentation of continuous hormone therapy, and written psychological assessment from a qualified mental health professional
21242	Arthroplasty, temporomandibular joint, with allograft	Prior Authorization Required	Medical Necessity	For dental review: Submit history and physical, pre-op evaluations, and documentation of medical necessity from a dental provider. Dental review fax is 425-918-5956.For gender affirming surgery: Submit history and physical, chart notes from the session(s) in which the diagnosis of gender dysphoria was determined, documentation of continuous hormone therapy, and written psychological assessment from a qualified mental health professional

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
21243	Arthroplasty, temporomandibular joint, with prosthetic joint replacement	Prior Authorization Required	Medical Necessity	For dental review: Submit history and physical, pre-op evaluations, and documentation of medical necessity from a dental provider. Dental review fax is 425-918-5956.For gender affirming surgery: Submit history and physical, chart notes from the session(s) in which the diagnosis of gender dysphoria was determined, documentation of continuous hormone therapy, and written psychological assessment from a qualified mental health professional
21244	Reconstruction of mandible, extraoral, with transosteal bone plate (eg, mandibular staple bone plate)	Prior Authorization Required	Medical Necessity	For dental review: Submit history and physical, pre-op evaluations, and documentation of medical necessity from a dental provider. Dental review fax is 425-918-5956.For gender affirming surgery: Submit history and physical, chart notes from the session(s) in which the diagnosis of gender dysphoria was determined, documentation of continuous hormone therapy, and written psychological assessment from a qualified mental health professional

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
21245	Reconstruction of mandible or maxilla, subperiosteal implant; partial	Prior Authorization Required	Medical Necessity	For dental review: Submit history and physical, pre-op evaluations, and documentation of medical necessity from a dental provider. Dental review fax is 425-918-5956.For gender affirming surgery: Submit history and physical, chart notes from the session(s) in which the diagnosis of gender dysphoria was determined, documentation of continuous hormone therapy, and written psychological assessment from a qualified mental health professional
21246	Reconstruction of mandible or maxilla, subperiosteal implant; complete	Prior Authorization Required	Medical Necessity	For dental review: Submit history and physical, pre-op evaluations, and documentation of medical necessity from a dental provider. Dental review fax is 425-918-5956.For gender affirming surgery: Submit history and physical, chart notes from the session(s) in which the diagnosis of gender dysphoria was determined, documentation of continuous hormone therapy, and written psychological assessment from a qualified mental health professional

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
21247	Reconstruction of mandibular condyle with bone and cartilage autografts (includes obtaining grafts) (eg, for hemifacial microsomia)	Prior Authorization Required	Medical Necessity	For dental review: Submit history and physical, pre-op evaluations, and documentation of medical necessity from a dental provider. Dental review fax is 425-918-5956.For gender affirming surgery: Submit history and physical, chart notes from the session(s) in which the diagnosis of gender dysphoria was determined, documentation of continuous hormone therapy, and written psychological assessment from a qualified mental health professional
21248	Reconstruction of mandible or maxilla, endosteal implant (eg, blade, cylinder); partial	Prior Authorization Required	Medical Necessity	For dental review: Submit history and physical, pre-op evaluations, and documentation of medical necessity from a dental provider. Dental review fax is 425-918-5956.For gender affirming surgery: Submit history and physical, chart notes from the session(s) in which the diagnosis of gender dysphoria was determined, documentation of continuous hormone therapy, and written psychological assessment from a qualified mental health professional

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
21249	Reconstruction of mandible or maxilla, endosteal implant (eg, blade, cylinder); complete	Prior Authorization Required	Medical Necessity	For dental review: Submit history and physical, pre-op evaluations, and documentation of medical necessity from a dental provider. Dental review fax is 425-918-5956.For gender affirming surgery: Submit history and physical, chart notes from the session(s) in which the diagnosis of gender dysphoria was determined, documentation of continuous hormone therapy, and written psychological assessment from a qualified mental health professional
21255	Reconstruction of zygomatic arch and glenoid fossa with bone and cartilage (includes obtaining autografts)	Prior Authorization Required	Medical Necessity	For dental review: Submit history and physical, pre-op evaluations, and documentation of medical necessity from a dental provider. Dental review fax is 425-918-5956
21256	Reconstruction of orbit with osteotomies (extracranial) and with bone grafts (includes obtaining autografts) (eg, micro-ophthalmia)	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, treatment history, operative report and anesthesia report
21260	Periorbital osteotomies for orbital hypertelorism, with bone grafts; extracranial approach	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, treatment history, operative report and anesthesia report
21261	Periorbital osteotomies for orbital hypertelorism, with bone grafts; combined intra- and extracranial approach	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, treatment history, operative report and anesthesia report

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
21263	Periorbital osteotomies for orbital hypertelorism, with bone grafts; with forehead advancement	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, treatment history, operative report and anesthesia report
21267	Orbital repositioning, periorbital osteotomies, unilateral, with bone grafts; extracranial approach	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, treatment history, operative report and anesthesia report
21268	Orbital repositioning, periorbital osteotomies, unilateral, with bone grafts; combined intra- and extracranial approach	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, treatment history, operative report and anesthesia report
21270	Malar augmentation, prosthetic material	Prior Authorization Required	Cosmetic	For dental review: Submit history and physical, cephalometric, panoramic films and photos, and age and history of orthodontic treatment; dental review fax is 425-918-5956.For gender affirming surgery: Submit history and physical, chart notes from the session(s) in which the diagnosis of gender dysphoria was determined, documentation of continuous hormone therapy, and written psychological assessment from a qualified mental health professional
21275	Secondary revision of orbitocraniofacial reconstruction	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, treatment history, operative report and anesthesia report
21280	Medial canthopexy (separate procedure)	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, and visual field
21282	Lateral canthopexy	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, and visual field

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
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, and 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, and procedure report
21299	Unlisted craniofacial and maxillofacial procedure	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, pre-operative evaluation, and operative report
21345	Closed treatment of nasomaxillary complex fracture (LeFort II type), with interdental wire fixation or fixation of denture or splint	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	Dental: Pre-op evaluations, history and physical, and documentation of medical necessity from a dental provider. Dental review fax 425-918-5956
21346	Open treatment of nasomaxillary complex fracture (LeFort II type); with wiring and/or local fixation	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	Dental: Pre-op evaluations, history and physical, and documentation of medical necessity from a dental provider. Dental review fax 425-918-5956
21347	Open treatment of nasomaxillary complex fracture (LeFort II type); requiring multiple open approaches	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	Dental: Pre-op evaluations, history and physical, and documentation of medical necessity from a dental provider. Dental review fax 425-918-5956
21348	Open treatment of nasomaxillary complex fracture (LeFort II type); with bone grafting (includes obtaining graft)	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	Dental: Pre-op evaluations, history and physical, and documentation of medical necessity from a dental provider. Dental review fax 425-918-5956
21355	Percutaneous treatment of fracture of malar area, including zygomatic arch and malar tripod, with manipulation	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	Dental: Pre-op evaluations, history and physical, and documentation of medical necessity from a dental provider. Dental review fax 425-918-5956

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21356	Open treatment of depressed zygomatic arch fracture (eg, Gillies approach)	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	Dental: Pre-op evaluations, history and physical, and documentation of medical necessity from a dental provider. Dental review fax 425-918-5956
21360	Open treatment of depressed malar fracture, including zygomatic arch and malar tripod	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	Dental: Pre-op evaluations, history and physical, and documentation of medical necessity from a dental provider. Dental review fax 425-918-5956
21365	Open treatment of complicated (eg, comminuted or involving cranial nerve foramina) fracture(s) of malar area, including zygomatic arch and malar tripod; with internal fixation and multiple surgical approaches	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	Dental: Pre-op evaluations, history and physical, and documentation of medical necessity from a dental provider. Dental review fax 425-918-5956
21366	Open treatment of complicated (eg, comminuted or involving cranial nerve foramina) fracture(s) of malar area, including zygomatic arch and malar tripod; with bone grafting (includes obtaining graft)	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	Dental: Pre-op evaluations, history and physical, and documentation of medical necessity from a dental provider. Dental review fax 425-918-5956
21421	Closed treatment of palatal or maxillary fracture (LeFort I type), with interdental wire fixation or fixation of denture or splint	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	Dental: Pre-op evaluations, history and physical, and documentation of medical necessity from a dental provider. Dental review fax 425-918-5956
21422	Open treatment of palatal or maxillary fracture (LeFort I type)	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	Dental: Pre-op evaluations, history and physical, and documentation of medical necessity from a dental provider. Dental review fax 425-918-5956
21423	Open treatment of palatal or maxillary fracture (LeFort I type); complicated (comminuted or involving cranial nerve foramina), multiple approaches	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	Dental: Pre-op evaluations, history and physical, and documentation of medical necessity from a dental provider. Dental review fax 425-918-5956

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
21431	Closed treatment of craniofacial separation (LeFort III type) using interdental wire fixation of denture or splint	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	Dental: Pre-op evaluations, history and physical, and documentation of medical necessity from a dental provider. Dental review fax 425-918-5956
21432	Open treatment of craniofacial separation (LeFort III type); with wiring and/or internal fixation	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	Dental: Pre-op evaluations, history and physical, and documentation of medical necessity from a dental provider. Dental review fax 425-918-5956
21433	Open treatment of craniofacial separation (LeFort III type); complicated (eg, comminuted or involving cranial nerve foramina), multiple surgical approaches	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	Dental: Pre-op evaluations, history and physical, and documentation of medical necessity from a dental provider. Dental review fax 425-918-5956
21435	Open treatment of craniofacial separation (LeFort III type); complicated, utilizing internal and/or external fixation techniques (eg, head cap, halo device, and/or intermaxillary fixation)	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	Dental: Pre-op evaluations, history and physical, and documentation of medical necessity from a dental provider. Dental review fax 425-918-5956
21436	Open treatment of craniofacial separation (LeFort III type); complicated, multiple surgical approaches, internal fixation, with bone grafting (includes obtaining graft)	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	Dental: Pre-op evaluations, history and physical, and documentation of medical necessity from a dental provider. Dental review fax 425-918-5956
21440	Closed treatment of mandibular or maxillary alveolar ridge fracture (separate procedure)	Prior Authorization Required	Medical Necessity	For dental review: Submit history and physical, pre-op evaluations, and documentation of medical necessity from a dental provider. Dental review fax is 425-918-5956
21445	Open treatment of mandibular or maxillary alveolar ridge fracture (separate procedure)	Prior Authorization Required	Medical Necessity	For dental review: Submit history and physical, pre-op evaluations, and documentation of medical necessity from a dental provider. Dental review fax is 425-918-5956

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21450	Closed treatment of mandibular fracture; without manipulation	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	Dental: Pre-op evaluations, history and physical, and documentation of medical necessity from a dental provider. Dental review fax 425-918-5956
21451	Closed treatment of mandibular fracture; with manipulation	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	Dental: Pre-op evaluations, history and physical, and documentation of medical necessity from a dental provider. Dental review fax 425-918-5956
21452	Percutaneous treatment of mandibular fracture, with external fixation	Prior Authorization Required	Medical Necessity	For dental review: Submit history and physical, pre-op evaluations, and documentation of medical necessity from a dental provider. Dental review fax is 425-918-5956
21453	Closed treatment of mandibular fracture with interdental fixation	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	Dental: Pre-op evaluations, history and physical, and documentation of medical necessity from a dental provider. Dental review fax 425-918-5956
21454	Open treatment of mandibular fracture with external fixation	Prior Authorization Required	Medical Necessity	For dental review: Submit history and physical, pre-op evaluations, and documentation of medical necessity from a dental provider. Dental review fax is 425-918-5956
21461	Open treatment of mandibular fracture; without interdental fixation	Prior Authorization Required	Medical Necessity	For dental review: Submit history and physical, pre-op evaluations, and documentation of medical necessity from a dental provider. Dental review fax is 425-918-5956
21462	Open treatment of mandibular fracture; with interdental fixation	Prior Authorization Required	Medical Necessity	For dental review: Submit history and physical, pre-op evaluations, and documentation of medical necessity from a dental provider. Dental review fax is 425-918-5956

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Code List

Code	Description	Plan Review Requirement	Reviewed For	Records Request
21465	Open treatment of mandibular condylar fracture	Prior Authorization Required	Medical Necessity	For dental review: Submit history and physical, pre-op evaluations, and documentation of medical necessity from a dental provider. Dental review fax is 425-918-5956
21470	Open treatment of complicated mandibular fracture by multiple surgical approaches including internal fixation, interdental fixation, and/or wiring of dentures or splints	Prior Authorization Required	Medical Necessity	For dental review: Submit history and physical, pre-op evaluations, and documentation of medical necessity from a dental provider. Dental review fax is 425-918-5956
21480	Closed treatment of temporomandibular dislocation; initial or subsequent	Prior Authorization Required	Medical Necessity	For dental review: Submit history and physical, pre-op evaluations, and documentation of medical necessity from a dental provider. Dental review fax is 425-918-5956
21485	Closed treatment of temporomandibular dislocation; complicated (eg, recurrent requiring intermaxillary fixation or splinting), initial or subsequent	Prior Authorization Required	Medical Necessity	For dental review: Submit history and physical, pre-op evaluations, and documentation of medical necessity from a dental provider. Dental review fax is 425-918-5956
21490	Open treatment of temporomandibular dislocation	Prior Authorization Required	Medical Necessity	For dental review: Submit history and physical, pre-op evaluations, and documentation of medical necessity from a dental provider. Dental review fax is 425-918-5956
21497	Interdental wiring, for condition other than fracture	Prior Authorization Required	Medical Necessity	For dental review: Submit history and physical, pre-op evaluations, and documentation of medical necessity from a dental provider. Dental review fax is 425-918-5956
21499	Unlisted musculoskeletal procedure, head	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical with operative/procedure report, as well as documentation to describe services
21740	Reconstructive repair of pectus excavatum or carinatum; open	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, imaging reports, and procedure report

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Code List

Code	Description	Plan Review Requirement	Reviewed For	Records Request
21742	minimally invasive approach (Nuss procedure) without thoracoscopy	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, imaging reports, and procedure report
21743	minimally invasive approach (Nuss Procedure), with thoracoscopy	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, imaging reports, and procedure report
21899	Unlisted procedure, neck or thorax	Advance Benefit Determination (ABD) recommended	Medical Necessity	For gender affirming surgery: Submit history and physical, documentation of gender dysphoria and any hormone therapy, as well as written psychological assessment from a qualified mental health provider. For non-gender affirming surgery: Submit history and physical, pre-operative evaluation, including functional impairment and operative report. Medical necessity review will be performed upon claims submission with supporting documentation
22010	Incision and drainage, open, of deep abscess (subfascial), posterior spine; cervical, thoracic, or cervicothoracic	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, imaging reports, and procedure report
22015	Incision and drainage, open, of deep abscess (subfascial), posterior spine; lumbar, sacral, or lumbosacral	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, imaging reports, and procedure report
22100	Partial excision of posterior vertebral component (eg, spinous process, lamina or facet) for intrinsic bony lesion, single vertebral segment; cervical	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, conservative measures, operative report, and anesthesia report
22101	Partial excision of posterior vertebral component (eg, spinous process, lamina or facet) for intrinsic bony lesion, single vertebral segment; thoracic	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, conservative measures, operative report, and anesthesia report

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Code List

Code	Description	Plan Review Requirement	Reviewed For	Records Request
22102	Partial excision of posterior vertebral component (eg, spinous process, lamina or facet) for intrinsic bony lesion, single vertebral segment; lumbar	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, conservative measures, operative report, and anesthesia report
22103	Partial excision of posterior vertebral component (eg, spinous process, lamina or facet) for intrinsic bony lesion, single vertebral segment; each additional segment (List separately in addition to code for primary procedure)	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, conservative measures, operative report, and anesthesia report
22110	Partial excision of vertebral body, for intrinsic bony lesion, without decompression of spinal cord or nerve root(s), single vertebral segment; cervical	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, conservative measures, operative report, and anesthesia report
22112	Partial excision of vertebral body, for intrinsic bony lesion, without decompression of spinal cord or nerve root(s), single vertebral segment; thoracic	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, conservative measures, operative report, and anesthesia report
22114	Partial excision of vertebral body, for intrinsic bony lesion, without decompression of spinal cord or nerve root(s), single vertebral segment; lumbar	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, conservative measures, operative report, and anesthesia report
22116	Partial excision of vertebral body, for intrinsic bony lesion, without decompression of spinal cord or nerve root(s), single vertebral segment; each additional vertebral segment (List separately in addition to code for primary procedure)	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, conservative measures, operative report, and anesthesia report

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Code List

Code	Description	Plan Review Requirement	Reviewed For	Records Request
22206	Osteotomy of spine, posterior or posterolateral approach, 3 columns, 1 vertebral segment (eg, pedicle/vertebral body subtraction); thoracic	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, conservative measures, operative report, and anesthesia report
22207	Osteotomy of spine, posterior or posterolateral approach, 3 columns, 1 vertebral segment (eg, pedicle/vertebral body subtraction); lumbar	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, conservative measures, operative report, and anesthesia report
22208	Osteotomy of spine, posterior or posterolateral approach, 3 columns, 1 vertebral segment (eg, pedicle/vertebral body subtraction); each additional vertebral segment (List separately in addition to code for primary procedure)	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, conservative measures, operative report, and anesthesia report
22210	Osteotomy of spine, posterior or posterolateral approach, 1 vertebral segment; cervical	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, conservative measures, operative report, and anesthesia report
22212	Osteotomy of spine, posterior or posterolateral approach, 1 vertebral segment; thoracic	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, conservative measures, operative report, and anesthesia report
22214	Osteotomy of spine, posterior or posterolateral approach, 1 vertebral segment; lumbar	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, conservative measures, operative report, and anesthesia report
22216	Osteotomy of spine, posterior or posterolateral approach, 1 vertebral segment; each additional vertebral segment (List separately in addition to primary procedure)	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, conservative measures, operative report, and anesthesia report

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Code List

Code	Description	Plan Review Requirement	Reviewed For	Records Request
22220	Osteotomy of spine, including discectomy, anterior approach, single vertebral segment; cervical	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, conservative measures, operative report, and anesthesia report
22222	Osteotomy of spine, including discectomy, anterior approach, single vertebral segment; thoracic	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, conservative measures, operative report, and anesthesia report
22224	Osteotomy of spine, including discectomy, anterior approach, single vertebral segment; lumbar	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, conservative measures, operative report, and anesthesia report
22226	Osteotomy of spine, including discectomy, anterior approach, single vertebral segment; each additional vertebral segment (List separately in addition to code for primary procedure)	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, conservative measures, operative report, and anesthesia report
22510	Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection, inclusive of all imaging guidance; cervicothoracic	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, documentation of medical necessity, and operative report
22511	Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection, inclusive of all imaging guidance; lumbosacral	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, documentation of medical necessity, and operative report

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
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	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, documentation of medical necessity, and 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	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, documentation of medical necessity, and 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	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, documentation of medical necessity, and operative report
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	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, documentation of medical necessity, and operative report
22526	Percutaneous intradiscal electrothermal annuloplasty, unilateral or bilateral including fluoroscopic guidance; single level	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, documentation of medical necessity, and operative report

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Code List

Code	Description	Plan Review Requirement	Reviewed For	Records Request
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)	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, documentation of medical necessity, and operative report
22532	Arthrodesis, lateral extracavitary technique, including minimal discectomy to prepare interspace (other than for decompression); thoracic	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, conservative measures, operative report, and anesthesia report
22533	Arthrodesis, lateral extracavitary technique, including minimal discectomy to prepare interspace (other than for decompression); lumbar	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, conservative measures, operative report, and anesthesia report
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	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, conservative measures, operative report, and anesthesia report
22548	Arthrodesis, anterior transoral or extraoral technique, clivus-C1-C2 (atlas-axis), with or without excision of odontoid process	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, conservative measures, operative report, and anesthesia report
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	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, conservative measures, operative report, and anesthesia report

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
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	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, conservative measures, operative report, and anesthesia report
22554	Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); cervical below C2	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, conservative measures, operative report, and anesthesia report
22556	Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); thoracic	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, conservative measures, operative report, and anesthesia report
22558	Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); lumbar	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, conservative measures, operative report, and anesthesia report
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	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, conservative measures, operative report, and anesthesia report
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 procedure/testing report

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Code List

Code	Description	Plan Review Requirement	Reviewed For	Records Request
22590	Arthrodesis, posterior technique, craniocervical (occiput-C2)	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, conservative measures, operative report, and anesthesia report
22595	Arthrodesis, posterior technique, atlas-axis (C1-C2)	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, conservative measures, operative report, and anesthesia report
22600	Arthrodesis, posterior or posterolateral technique, single level; cervical below C2 segment	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, conservative measures, operative report, and anesthesia report
22610	Arthrodesis, posterior or posterolateral technique, single interspace; thoracic (with lateral transverse technique, when performed)	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, conservative measures, operative report, and anesthesia report
22612	Arthrodesis, posterior or posterolateral technique, single level; lumbar (with or without lateral transverse technique)	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, conservative measures, operative report, and anesthesia report
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	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, conservative measures, operative report, and anesthesia report
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	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, conservative measures, operative report, and anesthesia report

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
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	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, conservative measures, operative report, and anesthesia report
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	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, conservative measures, operative report, and anesthesia report
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, documentation of medical necessity, pre-operative evaluations, imaging reports, conservative measures, operative report, and anesthesia report
22800	Arthrodesis, posterior, for spinal deformity, with or without cast; up to 6 vertebral segments	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, conservative measures, operative report, and anesthesia report
22802	Arthrodesis, posterior, for spinal deformity, with or without cast; 7 to 12 vertebral segments	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, conservative measures, operative report, and anesthesia report
22804	Arthrodesis, posterior, for spinal deformity, with or without cast; 13 or more vertebral segments	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, conservative measures, operative report, and anesthesia report

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Code List

Code	Description	Plan Review Requirement	Reviewed For	Records Request
22808	Arthrodesis, anterior, for spinal deformity, with or without cast; 2 to 3 vertebral segments	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, conservative measures, operative report, and anesthesia report
22810	Arthrodesis, anterior, for spinal deformity, with or without cast; 4 to 7 vertebral segments	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, conservative measures, operative report, and anesthesia report
22812	Arthrodesis, anterior, for spinal deformity, with or without cast; 8 or more vertebral segments	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, conservative measures, operative report, and anesthesia report
22818	Kyphectomy, circumferential exposure of spine and resection of vertebral segment(s) (including body and posterior elements); single or 2 segments	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, conservative measures, operative report, and anesthesia report
22819	Kyphectomy, circumferential exposure of spine and resection of vertebral segment(s) (including body and posterior elements); 3 or more segments	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, conservative measures, operative report, and anesthesia report
22830	Exploration of spinal fusion	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, conservative measures, operative report, and anesthesia report
22836	Anterior thoracic vertebral body tethering, including thoracoscopy, when performed; up to 7 vertebral segments	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, conservative measures, operative report, and anesthesia report

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
22837	Anterior thoracic vertebral body tethering, including thoracoscopy, when performed; 8 or more vertebral segments	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, conservative measures, operative report, and anesthesia report
22840	Posterior non-segmental instrumentation (eg, Harrington rod technique, pedicle fixation across 1 interspace, atlantoaxial transarticular screw fixation, sublaminar wiring at C1, facet screw fixation) (List separately in addition to code for primary procedure)	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, conservative measures, operative report, and anesthesia report
22841	Internal spinal fixation by wiring of spinous processes (List separately in addition to code for primary procedure)	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, conservative measures, operative report, and anesthesia report
22842	Posterior segmental instrumentation (eg, pedicle fixation, dual rods with multiple hooks and sublaminar wires); 3 to 6 vertebral segments (List separately in addition to code for primary procedure)	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, conservative measures, operative report, and anesthesia report
22843	Posterior segmental instrumentation (eg, pedicle fixation, dual rods with multiple hooks and sublaminar wires); 7 to 12 vertebral segments (List separately in addition to code for primary procedure)	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, conservative measures, operative report, and anesthesia report
22844	Posterior segmental instrumentation (eg, pedicle fixation, dual rods with multiple hooks and sublaminar wires); 13 or more vertebral segments (List separately in addition to code for primary procedure)	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, conservative measures, operative report, and anesthesia report

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
22845	Anterior instrumentation; 2 to 3 vertebral segments (List separately in addition to code for primary procedure)	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, conservative measures, operative report, and anesthesia report
22846	Anterior instrumentation; 4 to 7 vertebral segments (List separately in addition to code for primary procedure)	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, conservative measures, operative report, and anesthesia report
22847	Anterior instrumentation; 8 or more vertebral segments (List separately in addition to code for primary procedure)	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, conservative measures, operative report, and anesthesia report
22848	Pelvic fixation (attachment of caudal end of instrumentation to pelvic bony structures) other than sacrum (List separately in addition to code for primary procedure)	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, conservative measures, operative report, and anesthesia report
22849	Re INSERTion of spinal fixation device	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, conservative measures, operative report, and anesthesia report
22850	Removal of posterior nonsegmental instrumentation (eg, Harrington rod)	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, conservative measures, operative report, and anesthesia report
22852	Removal of posterior segmental instrumentation	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, conservative measures, operative report, and anesthesia report

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Code List

Code	Description	Plan Review Requirement	Reviewed For	Records Request
22853	Insertion of interbody biomechanical device(s) (eg, synthetic cage, mesh) with integral anterior instrumentation for device anchoring (eg, screws, flanges), when performed, to intervertebral disc space in conjunction with interbody arthrodesis, each interspace	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, conservative measures, operative report, and anesthesia report
22854	Insertion of intervertebral biomechanical device(s) (eg, synthetic cage, mesh) with integral anterior instrumentation for device anchoring (eg, screws, flanges), when performed, to vertebral corpectomy(ies) (vertebral body resection, partial or complete) defect, in conjunction with interbody arthrodesis, each contiguous defect	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, conservative measures, operative report, and anesthesia report
22855	Removal of anterior instrumentation	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, conservative measures, operative report, and anesthesia report
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	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, conservative measures, operative report, and anesthesia report
22857	Total disc arthroplasty (artificial disc), anterior approach, including discectomy to prepare interspace (other than for decompression); single interspace, lumbar	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, conservative measures, operative report, and anesthesia report

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
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	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, conservative measures, operative report, and anesthesia report
22859	Insertion of intervertebral biomechanical device(s) (eg, synthetic cage, mesh, methylmethacrylate) to intervertebral disc space or vertebral body defect without interbody arthrodesis, each contiguous defect	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, conservative measures, operative report, and anesthesia report
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	Medical Necessity	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, conservative measures, operative report, and anesthesia report
22861	Revision including replacement of total disc arthroplasty (artificial disc), anterior approach, single interspace; cervical	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, conservative measures, operative report, and anesthesia report
22862	Revision including replacement of total disc arthroplasty (artificial disc), anterior approach, single interspace; lumbar	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, conservative measures, operative report, and anesthesia report
22864	Removal of total disc arthroplasty (artificial disc), anterior approach, single interspace; cervical	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, conservative measures, operative report, and anesthesia report

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Code List

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	Medical Necessity	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, conservative measures, operative report, and anesthesia 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	Medical Necessity	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, conservative measures, operative report, and anesthesia 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	Medical Necessity	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, conservative measures, operative report, and anesthesia 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	Medical Necessity	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, conservative measures, operative report, and anesthesia 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	Medical Necessity	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, conservative measures, operative report, and anesthesia report
22899	Unlisted procedure, spine	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, operative/procedure report, and documentation to describe services
22999	Unlisted procedure, abdomen, musculoskeletal system	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, operative/procedure report, and documentation to describe services
23020	Capsular contracture release (eg, Sever type procedure)	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, and operative report

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Code List

Code	Description	Plan Review Requirement	Reviewed For	Records Request
23035	Incision, bone cortex (eg, osteomyelitis or bone abscess), shoulder area	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, and operative report
23040	Arthrotomy, glenohumeral joint, including exploration, drainage, or removal of foreign body	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, and operative report
23044	Arthrotomy, acromioclavicular, sternoclavicular joint, including exploration, drainage, or removal of foreign body	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, and operative report
23100	Arthrotomy, glenohumeral joint, including biopsy	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, and operative report
23101	Arthrotomy, acromioclavicular joint or sternoclavicular joint, including biopsy and/or excision of torn cartilage	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, and operative report
23105	Arthrotomy; glenohumeral joint, with synovectomy, with or without biopsy	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, and operative report
23106	Arthrotomy; sternoclavicular joint, with synovectomy, with or without biopsy	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, and operative report
23107	Arthrotomy, glenohumeral joint, with joint exploration, with or without removal of loose or foreign body	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, and operative report
23120	Claviculectomy; partial	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, and operative report

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
23125	Claviculectomy; total	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, and operative report
23130	Acromioplasty or acromionectomy, partial, with or without coracoacromial ligament release	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, and operative report
23170	Sequestrectomy (eg, for osteomyelitis or bone abscess), clavicle	Prior Authorization Required	Medical Necessity	History and physical, pre-op evaluations, imaging reports, documentation of non-operative conservative therapy measures, operative report, anesthesia report, and documentation of medical necessity
23172	Sequestrectomy (eg, for osteomyelitis or bone abscess), scapula	Prior Authorization Required	Medical Necessity	History and physical, pre-op evaluations, imaging reports, documentation of non-operative conservative therapy measures, operative report, anesthesia report, and documentation of medical necessity
23174	Sequestrectomy (eg, for osteomyelitis or bone abscess), humeral head to surgical neck	Prior Authorization Required	Medical Necessity	History and physical, pre-op evaluations, imaging reports, documentation of non-operative conservative therapy measures, operative report, anesthesia report, and documentation of medical necessity
23180	Partial excision (craterization, saucerization, or diaphysectomy) bone (eg, osteomyelitis), clavicle	Prior Authorization Required	Medical Necessity	History and physical, pre-op evaluations, imaging reports, documentation of non-operative conservative therapy measures, operative report, anesthesia report, and documentation of medical necessity

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Code List

Code	Description	Plan Review Requirement	Reviewed For	Records Request
23182	Partial excision (craterization, saucerization, or diaphysectomy) bone (eg, osteomyelitis), clavicle	Prior Authorization Required	Medical Necessity	History and physical, pre-op evaluations, imaging reports, documentation of non-operative conservative therapy measures, operative report, anesthesia report, and documentation of medical necessity
23184	Partial excision (craterization, saucerization, or diaphysectomy) bone (eg, osteomyelitis), proximal humerus	Prior Authorization Required	Medical Necessity	History and physical, pre-op evaluations, imaging reports, documentation of non-operative conservative therapy measures, operative report, anesthesia report, and documentation of medical necessity
23190	Ostectomy of scapula, partial (eg, superior medial angle)	Prior Authorization Required	Medical Necessity	History and physical, pre-op evaluations, imaging reports, documentation of non-operative conservative therapy measures, operative report, anesthesia report, and documentation of medical necessity
23195	Resection, humeral head	Prior Authorization Required	Medical Necessity	History and physical, pre-op evaluations, imaging reports, documentation of non-operative conservative therapy measures, operative report, anesthesia report, and documentation of medical necessity
23395	Muscle transfer, any type, shoulder or upper arm; single	Prior Authorization Required	Medical Necessity	History and physical, pre-op evaluations, imaging reports, documentation of non-operative conservative therapy measures, operative report, anesthesia report, and documentation of medical necessity
23397	Muscle transfer, any type, shoulder or upper arm; multiple	Prior Authorization Required	Medical Necessity	History and physical, pre-op evaluations, imaging reports, documentation of non-operative conservative therapy measures, operative report, anesthesia report, and documentation of medical necessity

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Code List

Code	Description	Plan Review Requirement	Reviewed For	Records Request
23400	Scapulopexy (eg, Sprengels deformity or for paralysis)	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history,physical and operative report
23405	Tenotomy, shoulder area; single tendon	Prior Authorization Required	Medical Necessity	History and physical, pre-op evaluations, imaging reports, documentation of non-operative conservative therapy measures, operative report, anesthesia report, and documentation of medical necessity
23406	Tenotomy, shoulder area; multiple tendons through same incision	Prior Authorization Required	Medical Necessity	History and physical, pre-op evaluations, imaging reports, documentation of non-operative conservative therapy measures, operative report, anesthesia report, and documentation of medical necessity
23410	Repair of ruptured musculotendinous cuff (eg, rotator cuff) open; acute	Prior Authorization Required	Medical Necessity	History and physical, pre-op evaluations, imaging reports, documentation of non-operative conservative therapy measures, operative report, anesthesia report, and documentation of medical necessity
23412	Repair of ruptured musculotendinous cuff (eg, rotator cuff) open; chronic	Prior Authorization Required	Medical Necessity	History and physical, pre-op evaluations, imaging reports, documentation of non-operative conservative therapy measures, operative report, anesthesia report, and documentation of medical necessity
23415	Coracoacromial ligament release, with or without acromioplasty	Prior Authorization Required	Medical Necessity	History and physical, pre-op evaluations, imaging reports, documentation of non-operative conservative therapy measures, operative report, anesthesia report, and documentation of medical necessity

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Code List

Code	Description	Plan Review Requirement	Reviewed For	Records Request
23420	Reconstruction of complete shoulder (rotator) cuff avulsion, chronic (includes acromioplasty)	Prior Authorization Required	Medical Necessity	History and physical, pre-op evaluations, imaging reports, documentation of non-operative conservative therapy measures, operative report, anesthesia report, and documentation of medical necessity
23430	Tenodesis of long tendon of biceps	Prior Authorization Required	Medical Necessity	History and physical, pre-op evaluations, imaging reports, documentation of non-operative conservative therapy measures, operative report, anesthesia report, and documentation of medical necessity
23440	Resection or transplantation of long tendon of biceps	Prior Authorization Required	Medical Necessity	History and physical, pre-op evaluations, imaging reports, documentation of non-operative conservative therapy measures, operative report, anesthesia report, and documentation of medical necessity
23450	Capsulorrhaphy, anterior; Putti-Platt procedure or Magnuson type operation	Prior Authorization Required	Medical Necessity	History and physical, pre-op evaluations, imaging reports, documentation of non-operative conservative therapy measures, operative report, anesthesia report, and documentation of medical necessity
23455	Capsulorrhaphy, anterior; with labral repair (e.g., Bankart procedure)	Prior Authorization Required	Medical Necessity	History and physical, pre-op evaluations, imaging reports, documentation of non-operative conservative therapy measures, operative report, anesthesia report, and documentation of medical necessity
23460	Capsulorrhaphy, anterior, any type; with bone block	Prior Authorization Required	Medical Necessity	History and physical, pre-op evaluations, imaging reports, documentation of non-operative conservative therapy measures, operative report, anesthesia report, and documentation of medical necessity

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
23462	Capsulorrhaphy, anterior, any type; with coracoid process transfer	Prior Authorization Required	Medical Necessity	History and physical, pre-op evaluations, imaging reports, documentation of non-operative conservative therapy measures, operative report, anesthesia report, and documentation of medical necessity
23465	Capsulorrhaphy, glenohumeral joint, posterior, with or without bone block	Prior Authorization Required	Medical Necessity	History and physical, pre-op evaluations, imaging reports, documentation of non-operative conservative therapy measures, operative report, anesthesia report, and documentation of medical necessity
23466	Capsulorrhaphy, glenohumeral joint, any type multi-directional instability	Prior Authorization Required	Medical Necessity	History and physical, pre-op evaluations, imaging reports, documentation of non-operative conservative therapy measures, operative report, anesthesia report, and documentation of medical necessity
23470	Arthroplasty, glenohumeral joint; hemiarthroplasty	Prior Authorization Required	Medical Necessity	History and physical, pre-op evaluations, imaging reports, documentation of non-operative conservative therapy, and physical measures, operative report, anesthesia report, and documentation of medical necessity
23472	Arthroplasty, glenohumeral joint; total shoulder (glenoid and proximal humeral replacement (eg, total shoulder))	Prior Authorization Required	Medical Necessity	History and physical, pre-op evaluations, imaging reports, documentation of non-operative conservative therapy, and physical measures, operative report, anesthesia report, and documentation of medical necessity

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Code List

Code	Description	Plan Review Requirement	Reviewed For	Records Request
23473	Revision of total shoulder arthroplasty, including allograft when performed; humeral or glenoid component	Prior Authorization Required	Medical Necessity	History and physical, pre-op evaluations, imaging reports, documentation of non-operative conservative therapy, and physical measures, operative report, anesthesia report, and documentation of medical necessity
23474	Revision of total shoulder arthroplasty, including allograft when performed; humeral and glenoid component	Prior Authorization Required	Medical Necessity	History and physical, pre-op evaluations, imaging reports, documentation of non-operative conservative therapy, and physical measures, operative report, anesthesia report, and documentation of medical necessity
23480	Osteotomy, clavicle, with or without internal fixation;	Prior Authorization Required	Medical Necessity	History and physical, pre-op evaluations, imaging reports, documentation of non-operative conservative therapy measures, operative report, anesthesia report, and documentation of medical necessity
23485	Osteotomy, clavicle, with or without internal fixation; with bone graft for nonunion or malunion (includes obtaining graft and/or necessary fixation)	Prior Authorization Required	Medical Necessity	History and physical, pre-op evaluations, imaging reports, documentation of non-operative conservative therapy measures, operative report, anesthesia report, and documentation of medical necessity
23490	Prophylactic treatment (nailing, pinning, plating or wiring) with or without methylmethacrylate; clavicle	Prior Authorization Required	Medical Necessity	History and physical, pre-op evaluations, imaging reports, documentation of non-operative conservative therapy measures, operative report, anesthesia report, and documentation of medical necessity

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Code List

Code	Description	Plan Review Requirement	Reviewed For	Records Request
23491	Prophylactic treatment (nailing, pinning, plating or wiring) with or without methylmethacrylate; proximal humerus	Prior Authorization Required	Medical Necessity	History and physical, pre-op evaluations, imaging reports, documentation of non-operative conservative therapy measures, operative report, anesthesia report, and documentation of medical necessity
23550	Open treatment of acromioclavicular dislocation, acute or chronic;	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, conservative measures, operative report, and anesthesia report
23552	Open treatment of acromioclavicular dislocation, acute or chronic; with fascial graft (includes obtaining graft)	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, conservative measures, operative report, and anesthesia report
23585	Open treatment of scapular fracture (body, glenoid or acromion) includes internal fixation, when performed	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, conservative measures, operative report, and anesthesia report
23615	Open treatment of proximal humeral (surgical or anatomical neck) fracture, includes internal fixation, when performed, includes repair of tuberosity(s), when performed;	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, conservative measures, operative report, and anesthesia report
23616	Open treatment of proximal humeral (surgical or anatomical neck) fracture, includes internal fixation, when performed, includes repair of tuberosity(s), when performed; with proximal humeral prosthetic replacement	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, conservative measures, operative report, and anesthesia report

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Code List

Code	Description	Plan Review Requirement	Reviewed For	Records Request
23630	Open treatment of greater humeral tuberosity fracture, includes internal fixation, when performed	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, conservative measures, operative report, and anesthesia report
23660	Open treatment of acute shoulder dislocation	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, conservative measures, operative report, and anesthesia report
23670	Open treatment of shoulder dislocation, with fracture of greater humeral tuberosity, includes internal fixation, when performed	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, conservative measures, operative report, and anesthesia report
23680	Open treatment of shoulder dislocation, with surgical or anatomical neck fracture, includes internal fixation, when performed	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, conservative measures, operative report, and anesthesia report
23700	Manipulation under anesthesia, shoulder joint, including application of fixation apparatus (dislocation excluded)	Prior Authorization Required	Medical Necessity	History and physical, pre-op evaluations, imaging reports, documentation of non-operative conservative therapy measures, operative report, anesthesia report, and documentation of medical necessity
23800	Arthrodesis, glenohumeral joint	Prior Authorization Required	Medical Necessity	History and physical, pre-op evaluations, imaging reports, documentation of non-operative conservative therapy measures, operative report, anesthesia report, and documentation of medical necessity

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
23802	Arthrodesis, glenohumeral joint; with autogenous graft (includes obtaining graft)	Prior Authorization Required	Medical Necessity	History and physical, pre-op evaluations, imaging reports, documentation of non-operative conservative therapy measures, operative report, anesthesia report, and documentation of medical necessity
23900	Interthoracoscapular amputation (forequarter)	Prior Authorization Required	Medical Necessity	History and physical, pre-op evaluations, imaging reports, documentation of non-operative conservative therapy measures, operative report, anesthesia report, and documentation of medical necessity
23920	Disarticulation of shoulder	Prior Authorization Required	Medical Necessity	History and physical, pre-op evaluations, imaging reports, documentation of non-operative conservative therapy measures, operative report, anesthesia report, and documentation of medical necessity
23921	Disarticulation of shoulder; secondary closure or scar revision	Prior Authorization Required	Medical Necessity	History and physical, pre-op evaluations, imaging reports, documentation of non-operative conservative therapy measures, operative report, anesthesia report, and documentation of medical necessity
23929	Unlisted procedure, shoulder	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, operative/procedure report, and documentation to describe services
24134	Sequestrectomy (eg, for osteomyelitis or bone abscess), shaft or distal humerus	Prior Authorization Required	Medical Necessity	History and physical, pre-op evaluations, imaging reports, documentation of non-operative conservative therapy measures, operative report, anesthesia report, and documentation of medical necessity
24140	Partial excision (craterization, saucerization, or diaphysectomy) bone (eg, osteomyelitis), humerus	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, and operative report

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Code List

Code	Description	Plan Review Requirement	Reviewed For	Records Request
24344	Reconstruction lateral collateral ligament, elbow, with tendon graft (includes harvesting of graft)	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, and operative report
24346	Reconstruction medial collateral ligament, elbow, with tendon graft (includes harvesting of graft)	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, and operative report
24498	Prophylactic treatment (nailing, pinning, plating or wiring), with or without methylmethacrylate, humeral shaft	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, and operative report
24999	Unlisted procedure, humerus or elbow	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, operative/procedure report, and documentation to describe services
25999	Unlisted procedure, forearm or wrist	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, pre-operative evaluation(s), imaging reports, conservative measures and response, operative/procedure report, anesthesia report and documentation of medical necessity
26341	Manipulation, palmar fascial cord (ie, Dupuytren's cord), post enzyme injection (eg, collagenase), single cord	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, documentation of medical necessity, and operative report
26500	Reconstruction of tendon pulley, each tendon; with local tissues (separate procedure)	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, and operative report
26502	Reconstruction of tendon pulley, each tendon; with tendon or fascial graft (includes obtaining graft) (separate procedure)	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, and operative report
26541	Reconstruction, collateral ligament, metacarpophalangeal joint, single; with tendon or fascial graft (includes obtaining graft)	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, and operative report

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
26542	Reconstruction, collateral ligament, metacarpophalangeal joint, single; with local tissue (eg, adductor advancement)	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, and operative report
26545	Reconstruction, collateral ligament, interphalangeal joint, single, including graft, each joint	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, and operative report
26989	Unlisted procedure, hands or fingers	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, operative/procedure report, and documentation to describe services
26992	Incision, bone cortex, pelvis and/or hip joint (eg, osteomyelitis or bone abscess)	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, and operative report
27000	Tenotomy, adductor of hip, percutaneous (separate procedure)	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, and operative report
27001	Tenotomy, adductor of hip, open	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, and operative report
27003	Tenotomy, adductor, subcutaneous, open, with obturator neurectomy	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, and operative report
27005	Tenotomy, hip flexor(s), open (separate procedure)	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, and operative report
27006	Tenotomy, abductors and/or extensor(s) of hip, open (separate procedure)	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, and operative report

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Code List

Code	Description	Plan Review Requirement	Reviewed For	Records Request
27025	Fasciotomy, hip or thigh, any type	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, and operative report
27027	Decompression fasciotomy(ies), pelvic (buttock) compartment(s) (eg, gluteus medius-minimus, gluteus maximus, iliopsoas, and/or tensor fascia lata muscle), unilateral	Prior Authorization Required	Medical Necessity	History and Physical, documentation of medical necessity
27030	Arthrotomy, hip, with drainage (eg, infection)	Prior Authorization Required	Medical Necessity	History and Physical, documentation of medical necessity
27033	Arthrotomy, hip, including exploration or removal of loose or foreign body	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, and operative report
27036	Capsulectomy or capsulotomy, hip, with or without excision of heterotopic bone, with release of hip flexor muscles (ie, gluteus medius, gluteus minimus, tensor fascia latae, rectus femoris, sartorius, iliopsoas)	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, and operative report
27050	Arthrotomy, with biopsy; sacroiliac joint	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, and operative report
27052	Arthrotomy, with biopsy; hip joint	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, and operative report
27054	Arthrotomy with synovectomy, hip joint	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, and operative report

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Code List

Code	Description	Plan Review Requirement	Reviewed For	Records Request
27057	Decompression fasciotomy(ies), pelvic (buttock) compartment(s) (eg, gluteus medius-minimus, gluteus maximus, iliopsoas, and/or tensor fascia lata muscle) with debridement of nonviable muscle, unilateral	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, and operative report
27070	Partial excision, wing of ilium, symphysis pubis, or greater trochanter of femur, (craterization, saucerization) (eg, osteomyelitis or bone abscess); superficial	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, and operative report
27071	Partial excision, wing of ilium, symphysis pubis, or greater trochanter of femur, (craterization, saucerization) (eg, osteomyelitis or bone abscess); deep (subfascial or intramuscular)	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, and operative report
27080	Coccygectomy, primary	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, and operative report
27097	Release or recession, hamstring, proximal	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, and operative report
27098	Transfer, adductor to ischium	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, and operative report
27125	Hemiarthroplasty, hip, partial (eg, femoral stem prosthesis, bipolar arthroplasty)	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, imaging reports and operative/procedure report
27130	Arthroplasty, acetabular and proximal femoral prosthetic replacement (total hip arthroplasty), with or without autograft or allograft	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, and operative report

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Code List

Code	Description	Plan Review Requirement	Reviewed For	Records Request
27132	Conversion of previous hip surgery to total hip arthroplasty, with or without autograft or allograft	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, and operative report
27134	Revision of total hip arthroplasty; both components, with or without autograft or allograft	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, and operative report
27137	Revision of total hip arthroplasty; acetabular component only, with or without autograft or allograft	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, and operative report
27138	Revision of total hip arthroplasty; femoral component only, with or without allograft	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, and operative report
27156	Osteotomy, iliac, acetabular or innominate bone; with femoral osteotomy and with open reduction of hip	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, and operative report
27158	Osteotomy, pelvis, bilateral (eg, congenital malformation)	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history,physical and operative report
27161	Osteotomy, femoral neck (separate procedure)	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, and operative report
27165	Osteotomy, intertrochanteric or subtrochanteric including internal or external fixation and/or cast	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, and operative report
27170	Bone graft, femoral head, neck, intertrochanteric or subtrochanteric area (includes obtaining bone graft)	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, and operative report

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Code List

Code	Description	Plan Review Requirement	Reviewed For	Records Request
27175	Treatment of slipped femoral epiphysis; by traction, without reduction	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, and operative report
27176	Treatment of slipped femoral epiphysis; by single or multiple pinning, in situ	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, and operative report
27177	Open treatment of slipped femoral epiphysis; single or multiple pinning or bone graft (includes obtaining graft)	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, and operative report
27178	Open treatment of slipped femoral epiphysis; closed manipulation with single or multiple pinning	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, and operative report
27179	Open treatment of slipped femoral epiphysis; osteoplasty of femoral neck (Heyman type procedure)	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, and operative report
27181	Open treatment of slipped femoral epiphysis; osteotomy and internal fixation	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, and operative report
27185	Epiphyseal arrest by epiphysiodesis or stapling, greater trochanter of femur	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, and operative report
27187	Prophylactic treatment (nailing, pinning, plating or wiring) with or without methylmethacrylate, femoral neck and proximal femur	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, and operative report
27258	Open treatment of spontaneous hip dislocation (developmental, including congenital or pathological), replacement of femoral head in acetabulum (including tenotomy, etc)	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history,physical and operative report

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Code List

Code	Description	Plan Review Requirement	Reviewed For	Records Request
27259	Open treatment of spontaneous hip dislocation (developmental, including congenital or pathological), replacement of femoral head in acetabulum (including tenotomy, etc); with femoral shaft shortening	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history,physical and operative report
27275	Manipulation, hip joint, requiring general anesthesia	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
27278	Arthrodesis, sacroiliac joint, percutaneous, percutaneous or minimally invasive, with image guidance, including obtaining bone graft when performed, unilateral; placement of intra-articular device(s), without cortical piercing	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, imaging reports and operative report
27279	Arthrodesis, sacroiliac joint, percutaneous or minimally invasive, with image guidance, includes obtaining bone graft when performed, unilateral; placement of transarticular device(s) and/or intra-articular device(s) piercing the lateral or medial cortices of the ilium and the lateral cortex of the sacrum	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, imaging reports and operative report
27280	Arthrodesis, sacroiliac joint, open, includes obtaining bone graft, including instrumentation, when performed	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, imaging reports and operative report
27282	Arthrodesis, symphysis pubis (including obtaining graft)	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, imaging reports and operative report
27284	Arthrodesis, hip joint (including obtaining graft)	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, imaging reports and operative report
27286	Arthrodesis, hip joint (including obtaining graft); with subtrochanteric osteotomy	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, imaging reports and operative report

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Code List

Code	Description	Plan Review Requirement	Reviewed For	Records Request
27290	Interpelviabdominal amputation (hindquarter amputation)	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, imaging reports and operative report
27295	Disarticulation of hip	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, imaging reports and operative report
27299	Unlisted procedure, pelvis or hip joint	Prior Authorization Required	Medical Necessity	If related to surgical hip arthroscopy (see CPT codes 29914, 29915, 29916), pre-op evaluations, imaging reports, conservative measures, operative report, anesthesia report, history and physical, and documentation of medical necessity.
27303	Incision, deep, with opening of bone cortex, femur or knee (eg, osteomyelitis or bone abscess)	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, imaging reports and operative/procedure report
27305	Fasciotomy, iliotibial (tenotomy), open	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, imaging reports and operative/procedure report
27306	Tenotomy, percutaneous, adductor or hamstring; single tendon (separate procedure)	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, imaging reports and operative/procedure report
27307	Tenotomy, percutaneous, adductor or hamstring; multiple tendons	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, imaging reports and operative/procedure report
27325	Neurectomy, hamstring muscle	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, imaging reports and operative/procedure report
27326	Neurectomy, popliteal (gastrocnemius)	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, imaging reports and operative/procedure report
27330	Arthrotomy, knee; with synovial biopsy only	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, imaging reports and operative/procedure report
27331	Arthrotomy, knee; including joint exploration, biopsy, or removal of loose or foreign bodies	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, imaging reports and operative/procedure report

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Code List

Code	Description	Plan Review Requirement	Reviewed For	Records Request
27332	Arthrotomy, with excision of semilunar cartilage (meniscectomy) knee; medial OR lateral	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, imaging reports and operative/procedure report
27333	Arthrotomy, with excision of semilunar cartilage (meniscectomy) knee; medial AND lateral	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, imaging reports and operative/procedure report
27334	Arthrotomy, with synovectomy, knee; anterior OR posterior	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, imaging reports and operative/procedure report
27335	Arthrotomy, with synovectomy, knee; anterior AND posterior including popliteal area	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, imaging reports and operative/procedure report
27350	Patellectomy or hemipatellectomy	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, imaging reports and operative/procedure report
27360	Partial excision (craterization, saucerization, or diaphysectomy) bone, femur, proximal tibia and/or fibula (eg, osteomyelitis or bone abscess)	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, imaging reports and operative/procedure report
27380	Suture of infrapatellar tendon; primary	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, imaging reports and operative/procedure report
27381	Suture of infrapatellar tendon; secondary reconstruction, including fascial or tendon graft	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, imaging reports and operative/procedure report
27385	Suture of quadriceps or hamstring muscle rupture; primary	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, imaging reports and operative/procedure report
27386	Suture of quadriceps or hamstring muscle rupture; secondary reconstruction, including fascial or tendon graft	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, imaging reports and operative/procedure report
27390	Tenotomy, open, hamstring, knee to hip; single tendon	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, imaging reports and operative/procedure report

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
27391	Tenotomy, open, hamstring, knee to hip; multiple tendons, 1 leg	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, imaging reports and operative/procedure report
27392	Tenotomy, open, hamstring, knee to hip; multiple tendons, bilateral	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, imaging reports and operative/procedure report
27393	Lengthening of hamstring tendon; single tendon	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, imaging reports and operative/procedure report
27394	Lengthening of hamstring tendon; multiple tendons, 1 leg	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, imaging reports and operative/procedure report
27395	Lengthening of hamstring tendon; multiple tendons, bilateral	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, imaging reports and operative/procedure report
27396	Transplant or transfer (with muscle redirection or rerouting), thigh (eg, extensor to flexor); single tendon	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, imaging reports and operative/procedure report
27397	Transplant or transfer (with muscle redirection or rerouting), thigh (eg, extensor to flexor); multiple tendons	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, imaging reports and operative/procedure report
27412	Autologous chondrocyte implantation, knee	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, imaging reports and operative/procedure report
27415	Osteochrondral allograft, knee, open	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, imaging reports and operative/procedure report
27416	Osteochondral autograft(s), knee, open (eg, mosaicplasty) (includes harvesting of autograft[s])	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, imaging reports and operative/procedure report
27427	Ligamentous reconstruction (augmentation), knee; extra-articular	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, imaging reports and operative/procedure report
27429	Ligamentous reconstruction (augmentation), knee; intra-articular (open) and extra-articular	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, imaging reports and operative/procedure report

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
27435	Capsulotomy, posterior capsular release, knee	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, imaging reports and operative/procedure report
27437	Arthroplasty, patella; without prosthesis	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, imaging reports and operative/procedure report
27438	Arthroplasty, patella; with prosthesis	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, imaging reports and operative/procedure report
27440	Arthroplasty, knee, tibial plateau;	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, imaging reports and operative/procedure report
27441	Arthroplasty, knee, tibial plateau; with debridement and partial synovectomy	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, imaging reports and operative/procedure report
27442	Arthroplasty, femoral condyles or tibial plateau(s), knee;	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, imaging reports and operative/procedure report
27443	Arthroplasty, femoral condyles or tibial plateau(s), knee; with debridement and partial synovectomy	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, imaging reports and operative/procedure report
27445	Arthroplasty, knee, hinge prosthesis (eg, Walldius type)	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, imaging reports and operative/procedure report
27446	Arthroplasty, knee, condyle and plateau; medial OR lateral compartment	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, imaging reports and operative/procedure report
27447	Arthroplasty, knee, condyle and plateau; medial AND lateral compartments with or without patella resurfacing (total knee arthroplasty)	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, imaging reports and operative/procedure report
27486	Revision of total knee arthroplasty, with or without allograft; 1 component	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, imaging reports and operative/procedure report
27487	Revision of total knee arthroplasty, with or without allograft; femoral and entire tibial component	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, imaging reports and operative/procedure report

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
27570	Manipulation of knee joint under general anesthesia (includes application of traction or other fixation devices)	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, imaging reports and operative/procedure report
27580	Arthrodesis, knee, any technique	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, imaging reports and operative/procedure report
27598	Disarticulation at knee	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, imaging reports and operative/procedure report
27599	Unlisted procedure femur or knee	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, operative/procedure report, and documentation to describe services
27600	Decompression fasciotomy, leg; anterior and/or lateral compartments only	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, imaging reports and operative/procedure report
27601	Decompression fasciotomy, leg; posterior compartment(s) only	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, imaging reports and operative/procedure report
27602	Decompression fasciotomy, leg; anterior and/or lateral, and posterior compartment(s)	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, imaging reports and operative/procedure report
27605	Tenotomy, percutaneous, Achilles tendon (separate procedure); local anesthesia	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, imaging reports and operative/procedure report
27606	Tenotomy, percutaneous, Achilles tendon (separate procedure); general anesthesia	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, imaging reports and operative/procedure report
27607	Incision (eg, osteomyelitis or bone abscess), leg or ankle	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, imaging reports and operative/procedure report
27612	Arthrotomy, posterior capsular release, ankle, with or without Achilles tendon lengthening	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, imaging reports and operative/procedure report
27620	Arthrotomy, ankle, with joint exploration, with or without biopsy, with or without removal of loose or foreign body	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, imaging reports and operative/procedure report

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Code List

Code	Description	Plan Review Requirement	Reviewed For	Records Request
27625	Arthrotomy, with synovectomy, ankle	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, imaging reports and operative/procedure report
27626	Arthrotomy, with synovectomy, ankle; including tenosynovectomy	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, imaging reports and operative/procedure report
27640	Partial excision (craterization, saucerization, or diaphysectomy), bone (eg, osteomyelitis); tibia	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, imaging reports and operative/procedure report
27641	Partial excision (craterization, saucerization, or diaphysectomy), bone (eg, osteomyelitis); fibula	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, imaging reports and operative/procedure report
27650	Repair, primary, open or percutaneous, ruptured Achilles tendon	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, imaging reports and operative/procedure report
27652	Repair, primary, open or percutaneous, ruptured Achilles tendon; with graft (includes obtaining graft)	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, imaging reports and operative/procedure report
27654	Repair, secondary, Achilles tendon, with or without graft	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, imaging reports and operative/procedure report
27656	Repair, fascial defect of leg	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, imaging reports and operative/procedure report
27658	Repair, flexor tendon, leg; primary, without graft, each tendon	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, imaging reports and operative/procedure report
27659	Repair, flexor tendon, leg; secondary, with or without graft, each tendon	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, imaging reports and operative/procedure report
27664	Repair, extensor tendon, leg; primary, without graft, each tendon	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, imaging reports and operative/procedure report
27665	Repair, extensor tendon, leg; secondary, with or without graft, each tendon	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, imaging reports and operative/procedure report

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
27675	Repair, dislocating peroneal tendons; without fibular osteotomy	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, imaging reports and operative/procedure report
27676	Repair, dislocating peroneal tendons; with fibular osteotomy	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, imaging reports and operative/procedure report
27680	Tenolysis, flexor or extensor tendon, leg and/or ankle; single, each tendon	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, imaging reports and operative/procedure report
27681	Tenolysis, flexor or extensor tendon, leg and/or ankle; multiple tendons (through separate incision[s])	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, imaging reports and operative/procedure report
27685	Lengthening or shortening of tendon, leg or ankle; single tendon (separate procedure)	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, imaging reports and operative/procedure report
27686	Lengthening or shortening of tendon, leg or ankle; multiple tendons (through same incision), each	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, imaging reports and operative/procedure report
27687	Gastrocnemius recession (eg, Strayer procedure)	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, imaging reports and operative/procedure report
27690	Transfer or transplant of single tendon (with muscle redirection or rerouting); superficial (eg, anterior tibial extensors into midfoot)	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, imaging reports and operative/procedure report
27691	Transfer or transplant of single tendon (with muscle redirection or rerouting); deep (eg, anterior tibial or posterior tibial through interosseous space, flexor digitorum longus, flexor hallucis longus, or peroneal tendon to midfoot or hindfoot)	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, imaging reports and operative/procedure report
27692	Transfer or transplant of single tendon (with muscle redirection or rerouting); each additional tendon (List separately in addition to code for primary procedure)	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, imaging reports and operative/procedure report

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
27695	Repair, primary, disrupted ligament, ankle; collateral	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, imaging reports and operative/procedure report
27696	Repair, primary, disrupted ligament, ankle; both collateral ligaments	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, imaging reports and operative/procedure report
27698	Repair, secondary, disrupted ligament, ankle, collateral (eg, Watson-Jones procedure)	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, imaging reports and operative/procedure report
27700	Arthroplasty, ankle;	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, imaging reports and operative/procedure report
27702	Arthroplasty, ankle; with implant (total ankle)	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, imaging reports and operative/procedure report
27703	Arthroplasty, ankle; revision, total ankle	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, imaging reports and operative/procedure report
27705	Osteotomy; tibia	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, imaging reports and operative/procedure report
27707	Osteotomy; fibula	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, imaging reports and operative/procedure report
27709	Osteotomy; tibia and fibula	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, imaging reports and operative/procedure report
27712	Osteotomy; multiple, with realignment on intramedullary rod (eg, Sofield type procedure)	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, imaging reports and operative/procedure report
27715	Osteoplasty, tibia and fibula, lengthening or shortening	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, imaging reports and operative/procedure report
27720	Repair of nonunion or malunion, tibia; without graft, (eg, compression technique)	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, imaging reports and operative/procedure report

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
27722	Repair of nonunion or malunion, tibia; with sliding graft	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, imaging reports and operative/procedure report
27724	Repair of nonunion or malunion, tibia; with iliac or other autograft (includes obtaining graft)	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, imaging reports and operative/procedure report
27725	Repair of nonunion or malunion, tibia; by synostosis, with fibula, any method	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, imaging reports and operative/procedure report
27726	Repair of fibula nonunion and/or malunion with internal fixation	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, imaging reports and operative/procedure report
27727	Repair of congenital pseudarthrosis, tibia	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history,physical and operative report
27730	Arrest, epiphyseal (epiphysiodesis), open; distal tibia	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, imaging reports and operative/procedure report
27732	Arrest, epiphyseal (epiphysiodesis), open; distal fibula	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, imaging reports and operative/procedure report
27734	Arrest, epiphyseal (epiphysiodesis), open; distal tibia and fibula	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, imaging reports and operative/procedure report
27740	Arrest, epiphyseal (epiphysiodesis), any method, combined, proximal and distal tibia and fibula	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, imaging reports and operative/procedure report
27742	Arrest, epiphyseal (epiphysiodesis), any method, combined, proximal and distal tibia and fibula; and distal femur	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, imaging reports and operative/procedure report
27745	Prophylactic treatment (nailing, pinning, plating or wiring) with or without methylmethacrylate, tibia	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, imaging reports and operative/procedure report
27860	Manipulation of ankle under general anesthesia (includes application of traction or other fixation apparatus)	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, imaging reports and operative/procedure report

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Code List

Code	Description	Plan Review Requirement	Reviewed For	Records Request
27870	Arthrodesis, ankle, open	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, imaging reports and operative/procedure report
27871	Arthrodesis, tibiofibular joint, proximal or distal	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, imaging reports and operative/procedure report
27889	Ankle disarticulation	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, imaging reports and operative/procedure report
27892	Decompression fasciotomy, leg; anterior and/or lateral compartments only, with debridement of nonviable muscle and/or nerve	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, imaging reports and operative/procedure report
27893	Decompression fasciotomy, leg; posterior compartment(s) only, with debridement of nonviable muscle and/or nerve	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, imaging reports and operative/procedure report
27894	Decompression fasciotomy, leg; anterior and/or lateral, and posterior compartment(s), with debridement of nonviable muscle and/or nerve	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, imaging reports and operative/procedure report
27899	Unlisted procedure, leg or ankle	Prior Authorization Required	Medical Necessity	History and physical, and documentation to describe what services were performed, in addition to the operative/procedure report
28005	Incision, bone cortex (eg, osteomyelitis or bone abscess), foot	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, imaging reports and operative/procedure report
28238	Reconstruction (advancement), posterior tibial tendon with excision of accessory tarsal navicular bone (eg, Kidner type procedure)	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, imaging reports and operative/procedure report
28291	Hallux rigidus correction with cheilectomy, debridement and capsular release of the first metatarsophalangeal joint; with implant	Advance Benefit Determination (ABD) recommended	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
28890	Extracorporeal shock wave, high energy, performed by a physician, requiring anesthesia other than local, including ultrasound guidance, involving the plantar fascia	Advance Benefit Determination (ABD) recommended	Investigative	Submit procedure/testing report
28899	Unlisted procedure, foot or toes	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, operative/procedure report, and documentation to describe services
29799	Unlisted procedure, casting or strapping	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, operative/procedure report, and documentation to describe services
29800	Arthroscopy, temporomandibular joint, diagnostic, with or without synovial biopsy (separate procedure)	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, imaging reports and operative/procedure report
29804	Arthroscopy, temporomandibular joint, surgical	Prior Authorization Required	Medical Necessity	For dental review: Submit history and physical, pre-op evaluations, and documentation of medical necessity from a dental provider. Dental review fax is 425-918-5956
29805	Arthroscopy, shoulder, diagnostic, with or without synovial biopsy (separate procedure)	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, conservative measures, operative report, and anesthesia report
29806	Arthroscopy, shoulder, surgical; capsulorrhaphy	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, imaging reports and operative/procedure report
29807	Arthroscopy, shoulder, surgical; repair of SLAP lesion	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, imaging reports and operative/procedure report
29819	Arthroscopy, shoulder, surgical; with removal of loose body or foreign body	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, conservative measures, operative report, and anesthesia report

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Code List

Code	Description	Plan Review Requirement	Reviewed For	Records Request
29820	Arthroscopy, shoulder, surgical; synovectomy, partial	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, imaging reports and operative/procedure report
29821	Arthroscopy, shoulder, surgical; synovectomy, complete	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, imaging reports and operative/procedure report
29822	Arthroscopy, shoulder, surgical; debridement, limited, 1 or 2 discrete structures (eg, humeral bone, humeral articular cartilage, glenoid bone, glenoid articular cartilage, biceps tendon, biceps anchor complex, labrum, articular capsule, articular side of the rotator cuff, bursal side of the rotator cuff, subacromial bursa, foreign body[ies])	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, imaging reports and operative/procedure report
29823	Arthroscopy, shoulder, surgical; debridement, extensive, 3 or more discrete structures (eg, humeral bone, humeral articular cartilage, glenoid bone, glenoid articular cartilage, biceps tendon, biceps anchor complex, labrum, articular capsule, articular side of the rotator cuff, bursal side of the rotator cuff, subacromial bursa, foreign body[ies])	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, imaging reports and operative/procedure report
29824	Arthroscopy, shoulder, surgical; distal claviculectomy including distal articular surface (Mumford procedure)	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, imaging reports and operative/procedure report
29825	Arthroscopy, shoulder, surgical; with lysis and resection of adhesions, with or without manipulation	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, imaging reports and operative/procedure report

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
29826	Arthroscopy, shoulder, surgical; decompression of subacromial space with partial acromioplasty, with coracoacromial ligament (i.e., arch) release, when performed (List separately in addition to code for primary procedure)	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, imaging reports and operative/procedure report
29827	Arthroscopy, shoulder, surgical; with rotator cuff repair	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, imaging reports and operative/procedure report
29828	Arthroscopy, shoulder, surgical; biceps tenodesis	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, imaging reports and operative/procedure report
29848	Endoscopy, wrist, surgical, with release of transverse carpal ligament	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, pre-op evaluations, imaging reports, conservative measures and response, operative/procedure report, anesthesia report, and documentation of medical necessity
29850	Arthroscopically aided treatment of intercondylar spine(s) and/or tuberosity fracture(s) of the knee, with or without manipulation; without internal or external fixation (includes arthroscopy)	Prior Authorization Required	Medical Necessity	History and physical, pre-op evaluation, documentation of medical necessity, imaging reports and operative/procedure report. For members that are 18 years old or younger, admin approve.
29851	Arthroscopically aided treatment of intercondylar spine(s) and/or tuberosity fracture(s) of the knee, with or without manipulation; with internal or external fixation (includes arthroscopy)	Prior Authorization Required	Medical Necessity	History and physical, pre-op evaluation, documentation of medical necessity, imaging reports and operative/procedure report. For members that are 18 years old or younger, admin approve.
29862	Arthroscopy, hip, surgical; with debridement/shaving of articular cartilage (chondroplasty), abrasion arthroplasty, and/or resection of labrum	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, imaging reports and operative/procedure report

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29863	Arthroscopy, hip, surgical; with synovectomy	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, imaging reports and operative/procedure report
29866	Arthroscopy, knee, surgical; osteochondral autograft(s) (eg, mosaicplasty) (includes harvesting of the autograft[s])	Prior Authorization Required	Medical Necessity	History and physical, pre-op evaluation, documentation of medical necessity, imaging reports and operative/procedure report. For members that are 18 years old or younger, admin approve.
29867	Arthroscopy, knee, surgical; osteochrondral allograft(s)	Prior Authorization Required	Medical Necessity	History and physical, pre-op evaluation, documentation of medical necessity, imaging reports and operative/procedure report. For members that are 18 years old or younger, admin approve.
29868	Arthroscopy, knee, surgical; meniscal transplantation, medial or lateral	Prior Authorization Required	Medical Necessity	History and physical, pre-op evaluation, documentation of medical necessity, imaging reports and operative/procedure report. For members that are 18 years old or younger, admin approve.
29870	Arthroscopy, knee, diagnostic, with or without synovial biopsy (separate procedure)	Prior Authorization Required	Medical Necessity	History and physical, pre-op evaluation, documentation of medical necessity, imaging reports and operative/procedure report. For members that are 18 years old or younger, admin approve.
29871	Arthroscopy, knee, surgical; for infection, lavage and drainage	Prior Authorization Required	Medical Necessity	History and physical, pre-op evaluation, documentation of medical necessity, imaging reports and operative/procedure report. For members that are 18 years old or younger, admin approve.

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Code List

Code	Description	Plan Review Requirement	Reviewed For	Records Request
29873	Arthroscopy, knee, surgical; with lateral release	Prior Authorization Required	Medical Necessity	History and physical, pre-op evaluation, documentation of medical necessity, imaging reports and operative/procedure report. For members that are 18 years old or younger, admin approve.
29874	Arthroscopy, knee, surgical; for removal of loose body or foreign body (eg, osteochondritis dissecans fragmentation, chondral fragmentation)	Prior Authorization Required	Medical Necessity	History and physical, pre-op evaluation, documentation of medical necessity, imaging reports and operative/procedure report. For members that are 18 years old or younger, admin approve.
29875	Arthroscopy, knee, surgical; synovectomy, limited (eg, plica or shelf resection) (separate procedure)	Prior Authorization Required	Medical Necessity	History and physical, pre-op evaluation, documentation of medical necessity, imaging reports and operative/procedure report. For members that are 18 years old or younger, admin approve.
29876	Arthroscopy, knee, surgical; synovectomy, major, 2 or more compartments (eg, medial or lateral)	Prior Authorization Required	Medical Necessity	History and physical, pre-op evaluation, documentation of medical necessity, imaging reports and operative/procedure report. For members that are 18 years old or younger, admin approve.
29877	Arthroscopy, knee, surgical; debridement/shaving of articular cartilage (chondroplasty)	Prior Authorization Required	Medical Necessity	History and physical, pre-op evaluation, documentation of medical necessity, imaging reports and operative/procedure report. For members that are 18 years old or younger, admin approve.
29879	Arthroscopy, knee, surgical; abrasion arthroplasty (includes chondroplasty where necessary) or multiple drilling or microfracture	Prior Authorization Required	Medical Necessity	History and physical, pre-op evaluation, documentation of medical necessity, imaging reports and operative/procedure report. For members that are 18 years old or younger, admin approve.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
29880	Arthroscopy, knee, surgical; with meniscectomy (medial AND lateral, including any meniscal shaving)	Prior Authorization Required	Medical Necessity	History and physical, pre-op evaluation, documentation of medical necessity, imaging reports and operative/procedure report. For members that are 18 years old or younger, admin approve.
29881	Arthroscopy, knee, surgical; with meniscectomy (medial OR lateral, including any meniscal shaving)	Prior Authorization Required	Medical Necessity	History and physical, pre-op evaluation, documentation of medical necessity, imaging reports and operative/procedure report. For members that are 18 years old or younger, admin approve.
29882	Arthroscopy, knee, surgical; with meniscus repair (medial OR lateral)	Prior Authorization Required	Medical Necessity	History and physical, pre-op evaluation, documentation of medical necessity, imaging reports and operative/procedure report. For members that are 18 years old or younger, admin approve.
29883	Arthroscopy, knee, surgical; with meniscus repair (medial AND lateral)	Prior Authorization Required	Medical Necessity	History and physical, pre-op evaluation, documentation of medical necessity, imaging reports and operative/procedure report. For members that are 18 years old or younger, admin approve.
29884	Arthroscopy, knee, surgical; with lysis of adhesions, with or without manipulation (separate procedure)	Prior Authorization Required	Medical Necessity	History and physical, pre-op evaluation, documentation of medical necessity, imaging reports and operative/procedure report. For members that are 18 years old or younger, admin approve.
29885	Arthroscopy, knee, surgical; drilling for osteochondritis dissecans with bone grafting, with or without internal fixation (including debridement of base of lesion)	Prior Authorization Required	Medical Necessity	History and physical, pre-op evaluation, documentation of medical necessity, imaging reports and operative/procedure report. For members that are 18 years old or younger, admin approve.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
29886	Arthroscopy, knee, surgical; drilling for intact osteochondritis dissecans lesion	Prior Authorization Required	Medical Necessity	History and physical, pre-op evaluation, documentation of medical necessity, imaging reports and operative/procedure report. For members that are 18 years old or younger, admin approve.
29887	Arthroscopy, knee, surgical; drilling for intact osteochondritis dissecans lesion with internal fixation	Prior Authorization Required	Medical Necessity	History and physical, pre-op evaluation, documentation of medical necessity, imaging reports and operative/procedure report. For members that are 18 years old or younger, admin approve.
29888	Arthroscopically aided anterior cruciate ligament repair/augmentation or reconstruction	Prior Authorization Required	Medical Necessity	History and physical, pre-op evaluation, documentation of medical necessity, imaging reports and operative/procedure report. For members that are 18 years old or younger, admin approve.
29889	Arthroscopically aided posterior cruciate ligament repair/augmentation or reconstruction	Prior Authorization Required	Medical Necessity	History and physical, pre-op evaluation, documentation of medical necessity, imaging reports and operative/procedure report. For members that are 18 years old or younger, admin approve.
29891	Arthroscopy, ankle, surgical, excision of osteochondral defect of talus and/or tibia, including drilling of the defect	Prior Authorization Required	Medical Necessity	History and physical, pre-op evaluation, documentation of medical necessity, imaging reports and operative/procedure report
29895	Arthroscopy, ankle (tibiotalar and fibulotalar joints), surgical; synovectomy, partial	Prior Authorization Required	Medical Necessity	History and physical, pre-op evaluation, documentation of medical necessity, imaging reports and operative/procedure report
29897	Arthroscopy, ankle (tibiotalar and fibulotalar joints), surgical; debridement, limited	Prior Authorization Required	Medical Necessity	History and physical, pre-op evaluation, documentation of medical necessity, imaging reports and operative/procedure report

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
29898	Arthroscopy, ankle (tibiotalar and fibulotalar joints), surgical; debridement, extensive	Prior Authorization Required	Medical Necessity	History and physical, pre-op evaluation, documentation of medical necessity, imaging reports and operative/procedure report
29899	with ankle arthrodesis (For open ankle arthrodesis, use 27870)	Prior Authorization Required	Medical Necessity	History and physical, pre-op evaluation, documentation of medical necessity, imaging reports and operative/procedure report
29914	Arthroscopy, hip, surgical; with femoroplasty (ie, treatment of cam lesion)	Prior Authorization Required	Medical Necessity	History and physical, pre-op evaluations, imaging reports, conservative measures, operative report, anesthesia report, and documentation of medical necessity
29915	Arthroscopy, hip, surgical; with acetabuloplasty (ie, treatment of pincer lesion)	Prior Authorization Required	Medical Necessity	History and physical, pre-op evaluations, imaging reports, conservative measures, operative report, anesthesia report, and documentation of medical necessity
29916	Arthroscopy, hip, surgical; with labral repair	Prior Authorization Required	Medical Necessity	History and physical, pre-op evaluation, documentation of medical necessity, imaging reports and operative/procedure report
29999	Unlisted procedure Arthroscopy	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, operative/procedure report, and documentation to describe services
30117	Excision or destruction (eg, laser), intranasal lesion; internal approach	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history and physical, documentation of medical necessity.
30120	Excision or surgical planing of skin of nose for rhinophyma	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history and physical, documentation of medical necessity.

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Code List

Code	Description	Plan Review Requirement	Reviewed For	Records Request
30400	Rhinoplasty, primary; lateral and alar cartilages and/or elevation of nasal tip	Prior Authorization Required	Cosmetic	For gender affirming surgery: Submit history and physical, documentation of gender dysphoria and any hormone therapy, as well as written psychological assessment from a qualified mental health provider. For non-gender affirming surgery: Submit history and physical, pre-operative evaluation, including functional impairment and operative report. Medical necessity review will be performed upon claims submission with supporting documentation
30410	Rhinoplasty, primary; complete, external parts including bony pyramid, lateral and alar cartilages, and/or elevation of nasal tip	Prior Authorization Required	Cosmetic	For gender affirming surgery: Submit history and physical, documentation of gender dysphoria and any hormone therapy, as well as written psychological assessment from a qualified mental health provider. For non-gender affirming surgery: Submit history and physical, pre-operative evaluation, including functional impairment and operative report. Medical necessity review will be performed upon claims submission with supporting documentation

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
30420	Rhinoplasty, primary; including major septal repair	Prior Authorization Required	Cosmetic	For gender affirming surgery: Submit history and physical, documentation of gender dysphoria and any hormone therapy, as well as written psychological assessment from a qualified mental health provider. For non-gender affirming surgery: Submit history and physical, pre-operative evaluation, including functional impairment and operative report. Medical necessity review will be performed upon claims submission with supporting documentation
30430	Rhinoplasty, secondary; minor revision (small amount of nasal tip work)	Prior Authorization Required	Cosmetic	For gender affirming surgery: Submit history and physical, documentation of gender dysphoria and any hormone therapy, as well as written psychological assessment from a qualified mental health provider. For non-gender affirming surgery: Submit history and physical, pre-operative evaluation, including functional impairment and operative report. Medical necessity review will be performed upon claims submission with supporting documentation

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
30435	Rhinoplasty, secondary; intermediate revision (bony work with osteotomies)	Prior Authorization Required	Cosmetic	For gender affirming surgery: Submit history and physical, documentation of gender dysphoria and any hormone therapy, as well as written psychological assessment from a qualified mental health provider. For non-gender affirming surgery: Submit history and physical, pre-operative evaluation, including functional impairment and operative report. Medical necessity review will be performed upon claims submission with supporting documentation
30450	Rhinoplasty, secondary; major revision (nasal tip work and osteotomies)	Prior Authorization Required	Cosmetic	For gender affirming surgery: Submit history and physical, documentation of gender dysphoria and any hormone therapy, as well as written psychological assessment from a qualified mental health provider. For non-gender affirming surgery: Submit history and physical, pre-operative evaluation, including functional impairment and operative report. Medical necessity review will be performed upon claims submission with supporting documentation
30460	Rhinoplasty for nasal deformity secondary to congenital cleft lip and/or palate, including columellar lengthening; tip only	Prior Authorization Required	Cosmetic	Submit history and physical, pre-operative evaluation, including functional impairment, and operative report
30462	Rhinoplasty for nasal deformity secondary to congenital cleft lip and/or palate, including columellar lengthening; tip, septum, osteotomies	Prior Authorization Required	Cosmetic	Submit history and physical, pre-operative evaluation, including functional impairment, and operative report
30468	Repair of nasal valve collapse with subcutaneous/submucosal lateral wall implant(s)	Advance Benefit Determination (ABD) recommended	Investigative	Submit history and physical, documentation of medical necessity and procedure report.

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30520	Septoplasty or submucous resection, with or without cartilage scoring, contouring or replacement with graft	Prior Authorization Required	Cosmetic	Submit history and physical, pre-operative evaluation, including functional impairment, and operative report
30999	Unlisted procedure, nose	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, operative/procedure report, and documentation to describe services
31242	Nasal/sinus endoscopy, surgical; with destruction by radiofrequency ablation, posterior nasal nerve	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	Submit history and physical, documentation of medical necessity.
31243	Nasal/sinus endoscopy, surgical; with destruction by cryoablation, posterior nasal nerve	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	Submit history and physical, documentation of medical necessity.
31295	Nasal/sinus endoscopy, surgical, with dilation (eg, balloon dilation); maxillary sinus ostium transnasal or via canine fossa	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, documentation of medical necessity, and procecdure report
31296	Nasal/sinus endoscopy, surgical, with dilation (eg, balloon dilation); frontal sinus ostium	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, documentation of medical necessity, and procecdure report
31297	Nasal/sinus endoscopy, surgical, with dilation (eg, balloon dilation) sphenoid sinus ostium	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, documentation of medical necessity, and procecdure report
31298	Nasal/sinus endoscopy, surgical, with dilation (eg, balloon dilation) frontal and sphenoid sinus ostia	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, documentation of medical necessity, and procecdure report
31299	Unlisted procedure, accessory sinuses	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, operative/procedure report, and documentation to describe services
31300	Laryngotomy (thyrotomy, laryngofissure), with removal of tumor or laryngocele, cordectomy	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, and operative/procecdure report

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31599	Unlisted procedure, larynx	Advance Benefit Determination (ABD) recommended	Medical Necessity	For gender affirming surgery: Submit history and physical, documentation of gender dysphoria and any hormone therapy, as well as written psychological assessment from a qualified mental health provider. For non-gender affirming surgery: Submit history and physical, pre-operative evaluation, including functional impairment and operative report. Medical necessity review will be performed upon claims submission with supporting documentation
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	Advance Benefit Determination (ABD) recommended	Investigative	Submit history and physical, documentation of medical necessity and procedure report.
31648	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with removal of bronchial valve(s), initial lobe	Advance Benefit Determination (ABD) recommended	Investigative	Submit history and physical, documentation of medical necessity and procedure report.
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)	Advance Benefit Determination (ABD) recommended	Investigative	Submit history and physical, documentation of medical necessity and procedure report.
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])	Advance Benefit Determination (ABD) recommended	Investigative	Submit history and physical, documentation of medical necessity and procedure report.

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31660	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with bronchial thermoplasty, 1 lobe	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
31661	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with bronchial thermoplasty, 2 or more lobes	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
31899	Unlisted procedure, trachea, bronchi	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, operative/procedure report, and documentation to describe services
32664	Thoracoscopy, surgical; with thoracic sympathectomy	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
32701	Thoracic target(s) delineation for stereotactic body radiation therapy (SRS/SBRT), (photon or particle beam), entire course of treatment	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, and documentation of medical necessity including tumor size and prior treatment. Medical necessity review will be performed upon claims submission with supporting documentation
32851	Lung transplant, single; without cardiopulmonary bypass	Prior Authorization Required	Medical Necessity	If transplant approval on record, then provide date of transplant; if no transplant approval on record, then provide history and physical, transplant evaluation, and date of transplant
32852	Lung transplant, single; with cardiopulmonary bypass	Prior Authorization Required	Medical Necessity	If transplant approval on record, then provide date of transplant; if no transplant approval on record, then provide history and physical, transplant evaluation, and date of transplant
32853	Lung transplant, double (bilateral sequential or en bloc); without cardiopulmonary bypass	Prior Authorization Required	Medical Necessity	If transplant approval on record, then provide date of transplant; if no transplant approval on record, then provide history and physical, transplant evaluation, and date of transplant

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Code List

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	If transplant approval on record, then provide date of transplant; if no transplant approval on record, then provide history and physical, transplant evaluation, and date of transplant
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	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, pre-operative evaluation, and operative 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	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, pre-operative evaluation, and operative report
32999	Unlisted procedure, lungs and pleura	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, operative/procedure report, and documentation to describe services
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	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
33275	Transcatheter removal of permanent leadless pacemaker, right ventricular, including imaging guidance (eg, fluoroscopy, venous ultrasound, ventriculography, femoral venography), when performed	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, documentation of medical necessity, and procedure report

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Code List

Code	Description	Plan Review Requirement	Reviewed For	Records Request
33285	Insertion, subcutaneous cardiac rhythm monitor, including programming	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
33289	Transcatheter implantation of wireless pulmonary artery pressure sensor for long-term hemodynamic monitoring, including deployment and calibration of the sensor, right heart	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
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	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	Submit history and physical, documentation of medical necessity.
33418	Transcatheter mitral valve repair, percutaneous approach, including transseptal puncture when performed; initial prosthesis	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, documentation of medical necessity, and procedure 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)	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
33814	Obliteration of aortopulmonary septal defect, with cardiopulmonary bypass	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history,physical and operative report
33927	Implantation of a total replacement heart system (artificial heart) with recipient cardiectomy	Prior Authorization Required	Medical Necessity	History and physical, pre-operative evaluation, operative report, documentation of medical necessity, and treatment plan
33928	Removal and replacement of total replacement heart system (artificial heart)	Prior Authorization Required	Medical Necessity	History and physical, pre-operative evaluation, operative report, documentation of medical necessity, and treatment plan

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Code List

Code	Description	Plan Review Requirement	Reviewed For	Records Request
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	History and physical, pre-operative evaluation, operative report, documentation of medical necessity, and treatment plan
33935	Heart-lung transplant with recipient cardiectomy- pneumonectomy	Prior Authorization Required	Medical Necessity	If transplant approval on record, then provide date of transplant; if no transplant approval on record, then provide history and physical, transplant evaluation, and date of transplant
33945	Heart transplant, with or without recipient cardiectomy	Prior Authorization Required	Medical Necessity	If transplant approval on record, then provide date of transplant; if no transplant approval on record, then provide history and physical, transplant evaluation, and date of transplant
33990	Insertion of ventricular assist device, percutaneous, including radiological supervision and interpretation; left heart, arterial access only	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, pre-operative evaluation, and operative report. Medical necessity review will be performed upon claims submission with supporting documentation
33991	Insertion of ventricular assist device, percutaneous, including radiological supervision and interpretation; left heart, both arterial and venous access, with transseptal puncture	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, pre-operative evaluation, and operative report. Medical necessity review will be performed upon claims submission with supporting documentation
33993	Repositioning of percutaneous right or left heart ventricular assist device with imaging guidance at separate and distinct session from insertion	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, pre-operative evaluation, and operative report. Medical necessity review will be performed upon claims submission with supporting documentation
33999	Unlisted procedure, cardiac surgery	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, operative/procedure report, and documentation to describe services

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Code List

Code	Description	Plan Review Requirement	Reviewed For	Records Request
34707	Endovascular repair of iliac artery by deployment of an ilio-iliac tube endograft including pre-procedure sizing and device selection, all nonselective catheterization(s), all associated radiological supervision and interpretation, and all endograft extension(s) proximally to the aortic bifurcation and distally to the iliac bifurcation, and treatment zone angioplasty/stenting, when performed, unilateral; for other than rupture (eg, for aneurysm, pseudoaneurysm, dissection, arteriovenous malformation)	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history,physical and operative report
34708	Endovascular repair of iliac artery by deployment of an ilio-iliac tube endograft including pre-procedure sizing and device selection, all nonselective catheterization(s), all associated radiological supervision and interpretation, and all endograft extension(s) proximally to the aortic bifurcation and distally to the iliac bifurcation, and treatment zone angioplasty/stenting, when performed, unilateral; for rupture including temporary aortic and/or iliac balloon occlusion, when performed (eg, for aneurysm, pseudoaneurysm, dissection, arteriovenous malformation, traumatic disruption)	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history,physical and operative report
35180	Repair, congenital arteriovenous fistula; head and neck	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history,physical and operative report
35182	Repair, congenital arteriovenous fistula; thorax and abdomen	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history,physical and operative report
35184	Repair, congenital arteriovenous fistula; extremities	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history,physical and operative report

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Code List

Code	Description	Plan Review Requirement	Reviewed For	Records Request
36299	Unlisted procedure, vascular injection	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, operative/procedure report, and documentation to describe services
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	History and physical, documentation of medical necessity, and procedure 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	History and physical, documentation of medical necessity, and procedure report
36468	Single or multiple injections of sclerosing solutions, spider veins (telangiectasia); limb or trunk	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
36470	Injection of sclerosing solution; single vein	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
36471	Injection of sclerosing solution; multiple veins, same leg	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
36473	Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, mechanochemical; first vein treated	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, and procedure report

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Code List

Code	Description	Plan Review Requirement	Reviewed For	Records Request
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	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
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	History and physical, documentation of medical necessity, and procedure 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	History and physical, documentation of medical necessity, and procedure 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	History and physical, documentation of medical necessity, and procedure report
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	History and physical, documentation of medical necessity, and procedure 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	History and physical, documentation of medical necessity, and procedure report

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
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	History and physical, documentation of medical necessity, and procedure report
36511	Therapeutic apheresis; for white blood cells	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, pre-operative evaluation, and operative report
36522	Photopheresis, extracorporeal	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, condition being treated, related diagostics, and operative report
37220	Revascularization, endovascular, open or percutaneous, iliac artery, unilateral, initial vessel; with transluminal angioplasty	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, pre-op evaluations, imaging reports, conservative measures and response, operative/procedure report, anesthesia report, and documentation of medical necessity
37221	Revascularization, endovascular, open or percutaneous, iliac artery, unilateral, initial vessel; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, pre-op evaluations, imaging reports, conservative measures and response, operative/procedure report, anesthesia report, and documentation of medical necessity
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)	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, pre-op evaluations, imaging reports, conservative measures and response, operative/procedure report, anesthesia report, and documentation of medical necessity

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
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)	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, pre-op evaluations, imaging reports, conservative measures and response, operative/procedure report, anesthesia report, and documentation of medical necessity
37224	Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with transluminal angioplasty	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, pre-op evaluations, imaging reports, conservative measures and response, operative/procedure report, anesthesia report, and documentation of medical necessity
37225	Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with atherectomy, includes angioplasty within the same vessel, when performed	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, pre-op evaluations, imaging reports, conservative measures and response, operative/procedure report, anesthesia report, and documentation of medical necessity
37226	Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, pre-op evaluations, imaging reports, conservative measures and response, operative/procedure report, anesthesia report, and documentation of medical necessity
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	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, pre-op evaluations, imaging reports, conservative measures and response, operative/procedure report, anesthesia report, and documentation of medical necessity

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
37228	Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with transluminal angioplasty	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, pre-op evaluations, imaging reports, conservative measures and response, operative/procedure report, anesthesia report, and documentation of medical necessity
37229	Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with atherectomy, includes angioplasty within the same vessel, when performed	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, pre-op evaluations, imaging reports, conservative measures and response, operative/procedure report, anesthesia report, and documentation of medical necessity
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	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, pre-op evaluations, imaging reports, conservative measures and response, operative/procedure report, anesthesia report, and documentation of medical necessity
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	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, pre-op evaluations, imaging reports, conservative measures and response, operative/procedure report, anesthesia report, and documentation of medical necessity
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)	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, pre-op evaluations, imaging reports, conservative measures and response, operative/procedure report, anesthesia report, and documentation of medical necessity
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)	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, pre-op evaluations, imaging reports, conservative measures and response, operative/procedure report, anesthesia report, and documentation of medical necessity

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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)	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, pre-op evaluations, imaging reports, conservative measures and response, operative/procedure report, anesthesia report, and documentation of medical necessity
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)	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, pre-op evaluations, imaging reports, conservative measures and response, operative/procedure report, anesthesia report, and documentation of medical necessity
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	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, pre-operative evaluation, and operative report
37500	Vascular endoscopy, surgical, with ligation of perforator veins, subfascial (SEPS)	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
37501	Unlisted vascular endoscopy procedure	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical with operative/procedure report, as well as documentation to describe services
37700	Ligation and division of long saphenous vein at saphenofemoral junction, or distal interruptions	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
37718	Ligation, division, and stripping, short saphenous vein	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, and procedure report

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
37722	Ligation, division, and stripping, long (greater) saphenous veins from saphenofemoral junction to knee or below	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
37735	Ligation and division and complete stripping of long or short saphenous veins with radical excision of ulcer and skin graft and/or interruption of communicating veins of lower leg, with excision of deep fascia	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
37760	Ligation of perforator veins, subfascial, radical (Linton type), including skin graft, when performed, open,1 leg	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
37761	Ligation of perforator vein(s), subfascial, open, including ultrasound guidance, when performed, 1 leg	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
37765	Stab phlebectomy of varicose veins, 1 extremity; 10-20 stab incisions	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
37766	Stab phlebectomy of varicose veins, 1 extremity; more than 20 incisions	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
37780	Ligation and division of short saphenous vein at saphenopopliteal junction (separate procedure)	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
37785	Ligation, division, and/or excision of varicose vein cluster(s), 1 leg	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
37799	Unlisted procedure, vascular surgery	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical with operative/procedure report, as well as documentation to describe services
38129	Unlisted laparoscopy procedure, spleen	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical with operative/procedure report, as well as documentation to describe services

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
38205	Blood-derived hematopoietic progenitor cell harvesting for transplantation, per collection; allogenic	Prior Authorization Required	Medical Necessity	If transplant approval on record, then provide date of transplant; if no transplant approval on record, then provide history and physical, transplant evaluation, and date of transplant
38206	Blood-derived hematopoietic progenitor cell harvesting for transplantation, per collection; autologous	Prior Authorization Required	Medical Necessity	If transplant approval on record, then provide date of transplant; if no transplant approval on record, then provide history and physical, transplant evaluation, and date of transplant
38207	Transplant preparation of hematopoietic progenitor cells; cryopreservation and storage	Prior Authorization Required	Medical Necessity	If transplant approval on record, then provide date of transplant; if no transplant approval on record, then provide history and physical, transplant evaluation, and date of transplant
38230	Bone marrow harvesting for transplantation; allogeneic	Prior Authorization Required	Medical Necessity	If transplant approval on record, then provide date of transplant; if no transplant approval on record, then provide history and physical, transplant evaluation, and date of transplant
38232	Bone marrow harvesting for transplantation; autologous	Prior Authorization Required	Medical Necessity	If transplant approval on record, then provide date of transplant; if no transplant approval on record, then provide history and physical, transplant evaluation, and date of transplant
38240	Hematopoietic progenitor cell (HPC); allogeneic transplantation per donor	Prior Authorization Required	Medical Necessity	If transplant approval on record, then provide date of transplant; if no transplant approval on record, then provide history and physical, transplant evaluation, and date of transplant
38241	Hematopoietic progenitor cell (HPC); autologous transplantation	Prior Authorization Required	Medical Necessity	If transplant approval on record, then provide date of transplant; if no transplant approval on record, then provide history and physical, transplant evaluation, and date of transplant

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
38589	Unlisted laparoscopy procedure, lymphatic system	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical with operative/procedure report, as well as documentation to describe services
38999	Unlisted procedure, hemic or lymphatic system	Advance Benefit Determination (ABD) recommended	Investigative	History and physical with operative/procedure report, as well as documentation to describe services. If service is not related to CAR T-cell therapy medical necessity review will be performed upon claims submission with supporting documentation.
39499	Unlisted procedure, mediastinum	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical with operative/procedure report, as well as documentation to describe services
39599	Unlisted procedure, diaphragm	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical with operative/procedure report, as well as documentation to describe services
40490	Biopsy of lip	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
40500	Vermilionectomy (lip shave), with mucosal advancement	Prior Authorization Required	Medical Necessity	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	Submit history and physical, pre-operative evaluation, including functional impairment, and operative report
40520	Excision of lip; V-excision with primary direct linear closure	Prior Authorization Required	Medical Necessity	Submit history and physical, pre-operative evaluation, including functional impairment, and operative report
40525	Excision of lip; full thickness, reconstruction with local flap (eg, Estlander or fan)	Prior Authorization Required	Medical Necessity	Submit history and physical, pre-operative evaluation, including functional impairment, and operative report

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40527	Excision of lip; full thickness, reconstruction with cross lip flap (Abbe-Estlander)	Prior Authorization Required	Medical Necessity	Submit history and physical, pre-operative evaluation, including functional impairment, and operative report
40530	Resection of lip, more than one-fourth, without reconstruction	Prior Authorization Required	Medical Necessity	Submit history and physical, pre-operative evaluation, including functional impairment, and operative report
40650	Repair lip, full thickness; vermilion only	Prior Authorization Required	Medical Necessity	Submit history and physical, pre-operative evaluation, including functional impairment, and operative report
40652	Repair lip, full thickness; up to half vertical height	Prior Authorization Required	Medical Necessity	Submit history and physical, pre-operative evaluation, including functional impairment, and operative report
40654	Repair lip, full thickness; over one-half vertical height, or complex	Prior Authorization Required	Medical Necessity	Submit history and physical, pre-operative evaluation, including functional impairment, and operative report
40700	Plastic repair of cleft lip/nasal deformity; primary, partial or complete, unilateral	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history,physical and operative report
40701	Plastic repair of cleft lip/nasal deformity; primary bilateral, 1-stage procedure	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, and documentation of medical necessity. medical necessity review will be performed upon claims submission with supporting documentation
40702	Plastic repair of cleft lip/nasal deformity; primary bilateral, 1 of 2 stages	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history,physical and operative report
40720	Plastic repair of cleft lip/nasal deformity; secondary, by recreation of defect and reclosure	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history,physical and operative report
40761	Plastic repair of cleft lip/nasal deformity; with cross lip pedicle flap (Abbe-Estlander type), including sectioning and INSERTing of pedicle	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history,physical and operative report

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Code List

Code	Description	Plan Review Requirement	Reviewed For	Records Request
40799	Unlisted procedure, lips	Advance Benefit Determination (ABD) recommended	Medical Necessity	For gender affirming surgery: Submit history and physical, documentation of gender dysphoria and any hormone therapy, as well as written psychological assessment from a qualified mental health provider. For non-gender affirming surgery: Submit history and physical, pre-operative evaluation, including functional impairment and operative report. Medical necessity review will be performed upon claims submission with supporting documentation
40800	Drainage of abscess, cyst, hematoma, vestibule of mouth; simple	Prior Authorization Required	Medical Necessity	Submit history and physical, pre-operative evaluation, including functional impairment, and operative report
40801	Drainage of abscess, cyst, hematoma, vestibule of mouth; complicated	Prior Authorization Required	Medical Necessity	Submit history and physical, pre-operative evaluation, including functional impairment, and operative report
40804	Removal of embedded foreign body, vestibule of mouth; simple	Prior Authorization Required	Medical Necessity	Submit history and physical, pre-operative evaluation, including functional impairment, and operative report
40805	Removal of embedded foreign body, vestibule of mouth; complicated	Prior Authorization Required	Medical Necessity	Submit history and physical, pre-operative evaluation, including functional impairment, and operative report
40806	Incision of labial frenum (frenotomy)	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
40808	Biopsy, vestibule of mouth	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, and procedure report

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Code List

Code	Description	Plan Review Requirement	Reviewed For	Records Request
40810	Excision of lesion of mucosa and submucosa, vestibule of mouth; without repair	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
40812	Excision of lesion of mucosa and submucosa, vestibule of mouth; with simple repair	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
40814	Excision of lesion of mucosa and submucosa, vestibule of mouth; with complex repair	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
40816	Excision of lesion of mucosa and submucosa, vestibule of mouth; complex, with excision of underlying muscle	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
40819	Excision of frenum, labial or buccal (frenumectomy, frenulectomy, frenectomy)	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
40820	Destruction of lesion or scar of vestibule of mouth by physical methods (eg, laser, thermal, cryo, chemical)	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
40830	Closure of laceration, vestibule of mouth; 2.5 cm or less	Prior Authorization Required	Medical Necessity	Submit history and physical, pre-operative evaluation, including functional impairment, and operative report
40831	Closure of laceration, vestibule of mouth; over 2.5 cm or complex	Prior Authorization Required	Medical Necessity	Submit history and physical, pre-operative evaluation, including functional impairment, and operative report
40840	Vestibuloplasty; anterior	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
40842	Vestibuloplasty; posterior, unilateral	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
40843	Vestibuloplasty; posterior, bilateral	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
40844	Vestibuloplasty; entire arch	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
40845	Vestibuloplasty; complex (including ridge extension, muscle repositioning)	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.

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40899	Unlisted procedure, vestibule of mouth	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical with operative/procedure report, as well as documentation to describe services
41000	Intraoral incision and drainage of abscess, cyst, or hematoma of tongue or floor of mouth; lingual	Prior Authorization Required	Medical Necessity	Submit history and physical, pre-operative evaluation, including functional impairment, and operative report
41005	Intraoral incision and drainage of abscess, cyst, or hematoma of tongue or floor of mouth; sublingual, superficial	Prior Authorization Required	Medical Necessity	Submit history and physical, pre-operative evaluation, including functional impairment, and operative report
41006	Intraoral incision and drainage of abscess, cyst, or hematoma of tongue or floor of mouth; sublingual, deep, supramylohyoid	Prior Authorization Required	Medical Necessity	Submit history and physical, pre-operative evaluation, including functional impairment, and operative report
41007	Intraoral incision and drainage of abscess, cyst, or hematoma of tongue or floor of mouth; submental space	Prior Authorization Required	Medical Necessity	Submit history and physical, pre-operative evaluation, including functional impairment, and operative report
41008	Intraoral incision and drainage of abscess, cyst, or hematoma of tongue or floor of mouth; submandibular space	Prior Authorization Required	Medical Necessity	Submit history and physical, pre-operative evaluation, including functional impairment, and operative report
41009	Intraoral incision and drainage of abscess, cyst, or hematoma of tongue or floor of mouth; masticator space	Prior Authorization Required	Medical Necessity	Submit history and physical, pre-operative evaluation, including functional impairment, and operative report
41010	Incision of lingual frenum (frenotomy)	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
41015	Extraoral incision and drainage of abscess, cyst, or hematoma of floor of mouth; sublingual	Prior Authorization Required	Medical Necessity	Submit history and physical, pre-operative evaluation, including functional impairment, and operative report

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
41016	Extraoral incision and drainage of abscess, cyst, or hematoma of floor of mouth; submental	Prior Authorization Required	Medical Necessity	Submit history and physical, pre-operative evaluation, including functional impairment, and operative report
41017	Extraoral incision and drainage of abscess, cyst, or hematoma of floor of mouth; submandibular	Prior Authorization Required	Medical Necessity	Submit history and physical, pre-operative evaluation, including functional impairment, and operative report
41018	Extraoral incision and drainage of abscess, cyst, or hematoma of floor of mouth; masticator space	Prior Authorization Required	Medical Necessity	Submit history and physical, pre-operative evaluation, including functional impairment, and operative report
41100	Biopsy of tongue; anterior two-thirds	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
41105	Biopsy of tongue; posterior one-third	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
41108	Biopsy of floor of mouth	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
41110	Excision of lesion of tongue without closure	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
41112	Excision of lesion of tongue with closure; anterior two-thirds	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
41113	Excision of lesion of tongue with closure; posterior one-third	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
41114	Excision of lesion of tongue with closure; with local tongue flap	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
41115	Excision of lingual frenum (frenectomy)	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, and procedure report

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
41116	Excision, lesion of floor of mouth	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
41120	Glossectomy; less than one-half tongue	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
41130	Glossectomy; hemiglossectomy	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
41150	Glossectomy; composite procedure with resection floor of mouth and mandibular resection, without radical neck dissection	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
41250	Repair of laceration 2.5 cm or less; floor of mouth and/or anterior two-thirds of tongue	Prior Authorization Required	Medical Necessity	Submit history and physical, pre-operative evaluation, including functional impairment, and operative report
41251	Repair of laceration 2.5 cm or less; posterior one-third of tongue	Prior Authorization Required	Medical Necessity	Submit history and physical, pre-operative evaluation, including functional impairment, and operative report
41252	Repair of laceration of tongue, floor of mouth, over 2.6 cm or complex	Prior Authorization Required	Medical Necessity	Submit history and physical, pre-operative evaluation, including functional impairment, and operative report
41512	Tongue base suspension, permanent suture technique	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history,physical and operative report
41520	Frenoplasty (surgical revision of frenum, eg, with Z-plasty)	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
41599	Unlisted procedure, tongue, floor of mouth	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical with operative/procedure report, as well as documentation to describe services
41820	Gingivectomy, excision gingiva, each quadrant	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
41821	Operculectomy, excision pericoronal tissues	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.

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41828	Excision of hyperplastic alveolar mucosa, each quadrant (specify)	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
41870	Periodontal mucosal grafting	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
41872	Gingivoplasty, each quadrant (specify)	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
41874	Alveoloplasty, each quadrant (specify)	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
41899	Unlisted procedure, dentoalveolar structures	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	Refer to dental for standard dental procedures; for all others allow per IHM instruction
42000	Drainage of abscess of palate, uvula	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
42100	Biopsy of palate, uvula	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
42104	Excision, lesion of palate, uvula; without closure	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
42106	Excision, lesion of palate, uvula; with simple primary closure	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
42107	Excision, lesion of palate, uvula; with local flap closure	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
42120	Resection of palate or extensive resection of lesion	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
42140	Uvulectomy, excision of uvula	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
42145	Palatopharyngoplasty (eg, uvulopalatopharyngoplasty, uvulopharyngoplasty)	Prior Authorization Required	Medical Necessity	History and physical and documentation of medical necessity, including sleep study results and results of CPAP trial

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
42160	Destruction of lesion, palate or uvula (thermal, cryo or chemical)	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
42180	Repair, laceration of palate; up to 2 cm	Prior Authorization Required	Medical Necessity	Submit history and physical, pre-operative evaluation, including functional impairment, and operative report
42182	Repair, laceration of palate; over 2 cm or complex	Prior Authorization Required	Medical Necessity	Submit history and physical, pre-operative evaluation, including functional impairment, and operative report
42200	Palatoplasty for cleft palate, soft and/or hard palate only	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history,physical and operative report
42205	Palatoplasty for cleft palate, with closure of alveolar ridge; soft tissue only	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history,physical and operative report
42210	Palatoplasty for cleft palate, with closure of alveolar ridge; with bone graft to alveolar ridge (includes obtaining graft)	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history,physical and operative report
42215	Palatoplasty for cleft palate; major revision	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history,physical and operative report
42220	Palatoplasty for cleft palate; secondary lengthening procedure	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history,physical and operative report
42225	Palatoplasty for cleft palate; attachment pharyngeal flap	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history,physical and operative report
42299	Unlisted procedure, palate, uvula	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical with operative/procedure report, as well as documentation to describe services
42300	Drainage of abscess; parotid, simple	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
42305	Drainage of abscess; parotid, complicated	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
42310	Drainage of abscess; submaxillary or sublingual, intraoral	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, and procedure report

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
42320	Drainage of abscess; submaxillary, external	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
42330	Sialolithotomy; submandibular (submaxillary), sublingual or parotid, uncomplicated, intraoral	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
42335	Sialolithotomy; submandibular (submaxillary), complicated, intraoral	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
42340	Sialolithotomy; parotid, extraoral or complicated intraoral	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
42699	Unlisted procedure, salivary glands or ducts	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical with operative/procedure report, as well as documentation to describe services
42950	Pharyngoplasty (plastic or reconstructive operation on pharynx)	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, including sleep study results, and results of CPAP trial
42999	Unlisted procedure, pharynx, adenoids, or tonsils	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical with operative/procedure report, as well as documentation to describe services
43201	Esophagoscopy, rigid or flexible; with directed submucosal injection(s), any substance	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history and physical, documentation of medical necessity and procedure report.
43206	Esophagoscopy, rigid or flexible; with optical endomicroscopy	Advance Benefit Determination (ABD) recommended	Investigative	Submit procedure/testing report
43252	Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with optical endomicroscopy	Advance Benefit Determination (ABD) recommended	Investigative	Submit procedure/testing report
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	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, pre-operative evaluation, and procedure report

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
43284	Laparoscopy, surgical, esophageal sphincter augmentation procedure, placement of sphincter augmentation device (ie, magnetic band), including cruroplasty when performed	Advance Benefit Determination (ABD) recommended	Investigative	Submit history and physical, documentation of medical necessity and procedure report.
43285	Removal of esophageal sphincter augmentation device	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history and physical, documentation of medical necessity and procedure report.
43289	Unlisted laparoscopy procedure, esophagus	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical with operative/procedure report, as well as documentation to describe services
43290	Esophagogastroduodenoscopy, flexible, transoral; with deployment of intragastric bariatric balloon	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
43291	Esophagogastroduodenoscopy, flexible, transoral; with removal of intragastric bariatric balloon(s)	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
43313	Esophagoplasty for congenital defect (plastic repair or reconstruction), thoracic approach; without repair of congenital tracheoesophageal fistula	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history,physical and operative report
43314	Esophagoplasty for congenital defect (plastic repair or reconstruction), thoracic approach; with repair of congenital tracheoesophageal fistula	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history,physical and operative report
43497	Lower esophageal myotomy, transoral (ie, peroral endoscopic myotomy [POEM])	Medical necessity review will be performed upon claims submission with supporting documentation	Investigative	Submit procedure/testing report
43499	Unlisted procedure, esophagus	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical with operative/procedure report, as well as documentation to describe services
43644	Laparoscopy, surgical, gastric restrictive procedure; with gastric bypass and Roux-en-Y gastroenterostomy	Prior Authorization Required	Medical Necessity	Office evaluation, including height and weight, treatment plan, and nutritional/dietician and mental health evaluations/visits

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
43645	Laparoscopy, surgical, gastric restrictive procedure; with gastric bypass small intestine reconstruction to limit absorption	Prior Authorization Required	Medical Necessity	Office evaluation, including height and weight, treatment plan, and nutritional/dietician and mental health evaluations/visits
43647	Laparoscopy, surgical; implantation or replacement of gastric neurostimulator electrodes, antrum	Advance Benefit Determination (ABD) recommended	Investigative	Submit procedure report. medical necessity review will be performed upon claims submission with supporting documentation
43648	Laparoscopy, surgical; revision or removal of gastric neurostimulator electrodes, antrum	Advance Benefit Determination (ABD) recommended	Investigative	Submit procedure report. medical necessity review will be performed upon claims submission with supporting documentation
43659	Unlisted laparoscopy procedure, stomach	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical with operative/procedure report, as well as documentation to describe services
43770	Laparoscopy, surgical, gastric restrictive procedure; placement of adjustable gastric band (gastric band and subcutaneous port components	Prior Authorization Required	Medical Necessity	Office evaluation, including height and weight, treatment plan, and nutritional/dietician and mental health evaluations/visits
43771	Laparoscopy, surgical, gastric restrictive procedure; revision of adjustable gastric band component only	Prior Authorization Required	Medical Necessity	Submit office evaluation including height and weight, treatment plan, and proposed procedure
43773	Laparoscopy, surgical, gastric restrictive procedure; removal and replacement of adjustable gastric band component only	Prior Authorization Required	Medical Necessity	Office evaluation, including height and weight, treatment plan, and nutritional/dietician and mental health evaluations/visits
43775	Laparoscopy, surgical, gastric restrictive procedure; longitudinal gastrectomy (ie, sleeve gastrectomy)	Prior Authorization Required	Medical Necessity	Office evaluation, including height and weight, treatment plan, and nutritional/dietician and mental health evaluations/visits
43842	Gastric restrictive procedure, without gastric bypass, for morbid obesity; vertical-banded gastroplasty	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
43843	Gastric restrictive procedure, without gastric bypass, for morbid obesity; other than vertical-banded gastroplasty	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.

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43845	Gastric restrictive procedure with partial gastrectomy, pylorus-preserving duodenoileostomy and ileoileostomy	Prior Authorization Required	Medical Necessity	Office evaluation, including height and weight, treatment plan, and nutritional/dietician and mental health evaluations/visits
43846	Gastric restrictive procedure, with gastric bypass for morbid obesity; with short limb (150 cm or less) Roux-en-Y gastroenterostomy	Prior Authorization Required	Medical Necessity	Office evaluation, including height and weight, treatment plan, and nutritional/dietician and mental health evaluations/visits
43847	Gastric restrictive procedure, with gastric bypass for morbid obesity; with small intestine reconstruction to limit absorption	Prior Authorization Required	Medical Necessity	Office evaluation, including height and weight, treatment plan, and nutritional/dietician and mental health evaluations/visits
43848	Revision, open, of gastric restrictive procedure for morbid obesity, other than adjustable gastric restrictive device (separate procedure)	Prior Authorization Required	Medical Necessity	Office evaluation, including height and weight, treatment plan, and nutritional/dietician and mental health evaluations/visits
43881	Implantation or replacement of gastric neurostimulator electrodes, antrum, open	Advance Benefit Determination (ABD) recommended	Investigative	Submit procedure report. medical necessity review will be performed upon claims submission with supporting documentation
43882	Revision or removal of gastric neurostimulator electrodes, antrum, open	Advance Benefit Determination (ABD) recommended	Investigative	Submit procedure report. medical necessity review will be performed upon claims submission with supporting documentation
43886	Gastric restrictive procedure, open; revision of subcutaneous port component only	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history and physical, documentation of medical necessity and procedure report.
43887	Gastric restrictive procedure, open; removal of subcutaneous port component only	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history and physical, documentation of medical necessity and procedure report.
43888	Gastric restrictive procedure, open; removal and replacement of subcutaneous port component only	Prior Authorization Required	Medical Necessity	Submit office evaluation including height and weight, treatment plan, and proposed procedure
43999	Unlisted procedure, stomach	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical with operative/procedure report, as well as documentation to describe services

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44126	Enterectomy, resection of small intestine for congenital atresia, single resection and anastomosis of proximal segment of intestine; without tapering	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history,physical and operative report
44127	Enterectomy, resection of small intestine for congenital atresia, single resection and anastomosis of proximal segment of intestine; with tapering	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history,physical and operative report
44128	Enterectomy, resection of small intestine for congenital atresia, single resection and anastomosis of proximal segment of intestine; each additional resection and anastomosis (List separately in addition to code for primary procedure)	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history,physical and operative report
44135	Intestinal allotransplantation; from cadaver donor	Prior Authorization Required	Medical Necessity	If transplant approval on record, then provide date of transplant; if no transplant approval on record, then provide history and physical, transplant evaluation, and date of transplant
44136	Intestinal allotransplantation; from living donor	Prior Authorization Required	Medical Necessity	If transplant approval on record, then provide date of transplant; if no transplant approval on record, then provide history and physical, transplant evaluation, and date of transplant
44238	Unlisted laparoscopy procedure, intestine (except rectum)	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical with operative/procedure report, as well as documentation to describe services
44799	Unlisted procedure, intestine	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical with operative/procedure report, as well as documentation to describe services
44899	Unlisted procedure, Meckel's diverticulum and the mesentery	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical with operative/procedure report, as well as documentation to describe services
44979	Unlisted laparoscopy procedure, appendix	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical with operative/procedure report, as well as documentation to describe services

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45399	Unlisted procedure, colon	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical with operative/procedure report, as well as documentation to describe services
45499	Unlisted laparoscopy procedure, rectum	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical with operative/procedure report, as well as documentation to describe services
45999	Unlisted procedure, rectum	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical with operative/procedure report, as well as documentation to describe services
46707	Repair of anorectal fistula with plug (eg, porcine small intestine submucosa [SIS])	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history,physical and operative report
46999	Unlisted procedure, anus	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical with operative/procedure report, as well as documentation to describe services
47135	Liver allotransplantation; orthoptic; partial or whole, from cadaver or	Prior Authorization Required	Medical Necessity	If transplant approval on record, then provide date of transplant; if no transplant approval on record, then provide history and physical, transplant evaluation, and date of transplant
47370	Laparoscopy, surgical, ablation of 1 or more liver tumor(s); radiofrequency	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history,physical and operative report
47371	Laparoscopy, surgical, ablation of 1 or more liver tumor(s); cryosurgical	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history,physical and operative report
47379	Unlisted laparoscopic procedure, liver	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical with operative/procedure report, as well as documentation to describe services
47380	Ablation, open, of 1 or more liver tumor(s); radiofrequency	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history,physical and operative report
47381	Ablation, open, of 1 or more liver tumor(s); cryosurgical	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history,physical and operative report
47382	Ablation, 1 or more liver tumor(s), percutaneous, radiofrequency	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history,physical and operative report
47383	Ablation, 1 or more liver tumor(s), percutaneous, cryoablation	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history,physical and operative report

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Code List

Code	Description	Plan Review Requirement	Reviewed For	Records Request
47399	Unlisted procedure, liver	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical with operative/procedure report, as well as documentation to describe services
47579	Unlisted laparoscopy procedure, biliary tract	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical with operative/procedure report, as well as documentation to describe services
47700	Exploration for congenital atresia of bile ducts, without repair, with or without liver biopsy, with or without cholangiography	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history,physical and operative report
47999	Unlisted procedure, biliary tract	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical with operative/procedure report, as well as documentation to describe services
48160	Pancreatectomy, total or subtotal, with autologous transplantation of pancreas or pancreatic islet cells	Prior Authorization Required	Medical Necessity	If transplant approval on record, then provide date of transplant; if no transplant approval on record, then provide history and physical, transplant evaluation, and date of transplant
48554	Transplantation of pancreatic allograft	Prior Authorization Required	Medical Necessity	If transplant approval on record, then provide date of transplant; if no transplant approval on record, then provide history and physical, transplant evaluation, and date of transplant
48999	Unlisted procedure, pancreas	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical with operative/procedure report, as well as documentation to describe services
49329	Unlisted laparoscopy procedure, abdomen, peritoneum and omentum	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical with operative/procedure report, as well as documentation to describe services
49591	Repair of anterior abdominal hernia(s) (ie, epigastric, incisional, ventral, umbilical, spigelian), any approach (ie, open, laparoscopic, robotic), initial, including implantation of mesh or other prosthesis when performed, total length of defect(s); less than 3 cm, reducible	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, conservative measures, operative report, and anesthesia report. For IP services- Prior authorization required. For OP services- Advance Benefit Determination (ABD) recommended.

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Code List

Code	Description	Plan Review Requirement	Reviewed For	Records Request
49593	Repair of anterior abdominal hernia(s) (ie, epigastric, incisional, ventral, umbilical, spigelian), any approach (ie, open, laparoscopic, robotic), initial, including implantation of mesh or other prosthesis when performed, total length of defect(s); 3 cm to 10 cm, reducible	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, conservative measures, operative report, and anesthesia report. For IP services- Prior authorization required. For OP services- Advance Benefit Determination (ABD) recommended.
49595	Repair of anterior abdominal hernia(s) (ie, epigastric, incisional, ventral, umbilical, spigelian), any approach (ie, open, laparoscopic, robotic), initial, including implantation of mesh or other prosthesis when performed, total length of defect(s); greater than 10 cm, reducible	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, conservative measures, operative report, and anesthesia report. For IP services- Prior authorization required. For OP services- Advance Benefit Determination (ABD) recommended.
49613	Repair of anterior abdominal hernia(s) (ie, epigastric, incisional, ventral, umbilical, spigelian), any approach (ie, open, laparoscopic, robotic), recurrent, including implantation of mesh or other prosthesis when performed, total length of defect(s); less than 3 cm, reducible	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, conservative measures, operative report, and anesthesia report. For IP services- Prior authorization required. For OP services- Advance Benefit Determination (ABD) recommended.
49615	Repair of anterior abdominal hernia(s) (ie, epigastric, incisional, ventral, umbilical, spigelian), any approach (ie, open, laparoscopic, robotic), recurrent, including implantation of mesh or other prosthesis when performed, total length of defect(s); 3 cm to 10 cm, reducible	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, conservative measures, operative report, and anesthesia report. For IP services- Prior authorization required. For OP services- Advance Benefit Determination (ABD) recommended.

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Code List

Code	Description	Plan Review Requirement	Reviewed For	Records Request
49617	Repair of anterior abdominal hernia(s) (ie, epigastric, incisional, ventral, umbilical, spigelian), any approach (ie, open, laparoscopic, robotic), recurrent, including implantation of mesh or other prosthesis when performed, total length of defect(s); greater than 10 cm, reducible	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, conservative measures, operative report, and anesthesia report. For IP services- Prior authorization required. For OP services- Advance Benefit Determination (ABD) recommended.
49659	Unlisted laparoscopy procedure, hernioplasty, herniorrhaphy, herniotomy	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical with operative/procedure report, as well as documentation to describe services
49999	Unlisted procedure, abdomen, peritoneum and omentum	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical with operative/procedure report, as well as documentation to describe services
50070	Nephrolithotomy; complicated by congenital kidney abnormality	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history,physical and operative report
50250	Ablation, open, 1 or more renal mass lesion(s), cryosurgical, including intraoperative ultrasound guidance and monitoring, if performed	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, documentation of medical necessity, and operative report
50300	Donor nephrectomy (including cold preservation); from cadaver donor, unilateral or bilateral	Prior Authorization Required	Medical Necessity	History and physical, transplant evaluation, and date of transplant
50320	Donor nephrectomy (including cold preservation); open, from living donor	Prior Authorization Required	Medical Necessity	History and physical, transplant evaluation, and date of transplant
50323	Backbench standard preparation of cadaver donor renal allograft prior to transplantation	Prior Authorization Required	Medical Necessity	History and physical, transplant evaluation, and date of transplant
50325	Backbench standard preparation of living donor renal allograft (open or laparoscopic) prior to transplantation, including dissection and removal of perinephric fat and preparation of ureter(s), renal vein(s), and renal artery(s), ligating branches, as necessary	Prior Authorization Required	Medical Necessity	History and physical, transplant evaluation, and date of transplant

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Code List

Code	Description	Plan Review Requirement	Reviewed For	Records Request
50327	Backbench reconstruction of cadaver or living donor renal allograft prior to transplantation; venous anastomosis, each	Prior Authorization Required	Medical Necessity	History and physical, transplant evaluation, and date of transplant
50328	Backbench reconstruction of cadaver or living donor renal allograft prior to transplantation; arterial anastomosis, each	Prior Authorization Required	Medical Necessity	History and physical, transplant evaluation, and date of transplant
50329	Backbench reconstruction of cadaver or living donor renal allograft prior to transplantation; ureteral anastomosis, each	Prior Authorization Required	Medical Necessity	History and physical, transplant evaluation, and date of transplant
50340	Recipient nephrectomy (separate procedure)	Prior Authorization Required	Medical Necessity	History and physical, transplant evaluation, and date of transplant
50360	Renal allotransplantation; implantation of graft; without recipient	Prior Authorization Required	Medical Necessity	History and physical, transplant evaluation, and date of transplant
50365	Renal allotransplantation, implantation of graft; with recipient nephrectomy	Prior Authorization Required	Medical Necessity	History and physical, transplant evaluation, and date of transplant
50380	Renal autotransplantation, reimplantation of kidney	Prior Authorization Required	Medical Necessity	History and physical, transplant evaluation, and date of transplant
50405	Pyeloplasty (Foley Y-pyeloplasty), plastic operation on renal pelvis, with or without plastic operation on ureter, nephropexy, nephrostomy, pyelostomy, or ureteral splinting; complicated (congenital kidney abnormality, secondary pyeloplasty, solitary kidney, calycoplasty)	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history,physical and operative report
50542	Laparoscopy, surgical; ablation of renal mass lesion(s), including intraoperative ultrasound guidance and monitoring, when performed	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history,physical and operative report

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Code List

Code	Description	Plan Review Requirement	Reviewed For	Records Request
50547	Laparoscopy, surgical; donor nephrectomy (including cold preservation), from living donor	Prior Authorization Required	Medical Necessity	Recipient's history and physical, transplant evaluation, and date of transplant. Note: Benefits are available for donor nephrectomy only when recipient is a BCBS FEP member and transplant has been approved
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	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, operative/procedure report, and documentation to describe services
50593	Ablation, renal tumor(s), unilateral, percutaneous, cryotherapy	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, operative/procedure report, and documentation to describe services
51999	Unlisted laparoscopy procedure bladder	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical with operative/procedure report, as well as documentation to describe services
52327	Cystourethroscopy (including ureteral catheterization); with subureteric injection of implant material	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history and physical, documentation of medical necessity and procedure report.
52400	Cystourethroscopy with incision, fulguration, or resection of congenital posterior urethral valves, or congenital obstructive hypertrophic mucosal folds	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history,physical and operative report
52441	Cystourethroscopy, with insertion of permanent adjustable transprostatic implant; single implant	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, and documentation of medical necessity, including tried medical treatments
52442	Cystourethroscopy, with insertion of permanent adjustable transprostatic implant; each additional permanent adjustable transprostatic implant	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, and documentation of medical necessity, including tried medical treatments

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Code List

Code	Description	Plan Review Requirement	Reviewed For	Records Request
53410	Urethroplasty, 1-stage reconstruction of male anterior urethra	Prior Authorization Required	Gender Affirming Surgery	For gender affirming surgery: Submit history and physical, chart notes from the session(s) in which the diagnosis of gender dysphoria was determined, documentation of continuous hormone therapy, and written psychological assessment from a qualified mental health professional
53420	Urethroplasty, 2-stage reconstruction or repair of prostatic or membranous urethra; first stage	Prior Authorization Required	Gender Affirming Surgery	History and physical, chart notes from session(s) where gender dysphoria was determined, documentation and duration of hormone therapy; two referral letters from qualified mental health providers - one must be psychotherapist treating the member for at least 12 continuous months. Note: The prior approval request must include all surgical procedures anticipated/planned to change the member's biological gender, where the procedure(s) will be performed and the estimated date(s) for the procedures.
53425	Urethroplasty, 2-stage reconstruction or repair of prostatic or membranous urethra; second stage	Prior Authorization Required	Gender Affirming Surgery	History and physical, chart notes from session(s) where gender dysphoria was determined, documentation and duration of hormone therapy; two referral letters from qualified mental health providers - one must be psychotherapist treating the member for at least 12 continuous months. Note: The prior approval request must include all surgical procedures anticipated/planned to change the member's biological gender, where the procedure(s) will be performed and the estimated date(s) for the procedures.

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Code List

Code	Description	Plan Review Requirement	Reviewed For	Records Request
53430	Urethroplasty, reconstruction of female urethra	Prior Authorization Required	Gender Affirming Surgery	For gender affirming surgery: Submit history and physical, chart notes from the session(s) in which the diagnosis of gender dysphoria was determined, documentation of continuous hormone therapy, and written psychological assessment from a qualified mental health professional. For non-gender affirming surgery: Medical necessity review will be performed upon claims submission with supporting documentation.
53865	Cystourethroscopy with insertion of temporary device for ischemic remodeling (ie, pressure necrosis) of bladder neck and prostate	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, documentation of medical necessity, and operative report
53866	Catheterization with removal of temporary device for ischemic remodeling (ie, pressure necrosis) of bladder neck and prostate	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, documentation of medical necessity, and operative report
53899	Unlisted urinary procedure	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical with operative/procedure report, as well as documentation to describe services
54125	Amputation of penis; complete	Prior Authorization Required	Gender Affirming Surgery	For gender affirming surgery: Submit history and physical, chart notes from the session(s) in which the diagnosis of gender dysphoria was determined, documentation of continuous hormone therapy, and written psychological assessment from a qualified mental health professional. For non-gender affirming surgery: Medical necessity review will be performed upon claims submission with supporting documentation.

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Code List

Code	Description	Plan Review Requirement	Reviewed For	Records Request
54400	Insertion of penile prosthesis; non-inflatable (semi-rigid)	Prior Authorization Required	Gender Affirming Surgery	For gender affirming surgery: Submit history and physical, chart notes from the session(s) in which the diagnosis of gender dysphoria was determined, documentation of continuous hormone therapy, and written psychological assessment from a qualified mental health professional. For non-gender affirming surgery: Medical necessity review will be performed upon claims submission with supporting documentation.
54401	Insertion of penile prosthesis; inflatable (self-contained)	Prior Authorization Required	Gender Affirming Surgery	For gender affirming surgery: Submit history and physical, chart notes from the session(s) in which the diagnosis of gender dysphoria was determined, documentation of continuous hormone therapy, and written psychological assessment from a qualified mental health professional. For non-gender affirming surgery: Medical necessity review will be performed upon claims submission with supporting documentation.
54405	Insertion of multi-component, inflatable penile prosthesis, including placement of pump, cylinders, and reservoir	Prior Authorization Required	Gender Affirming Surgery	For gender affirming surgery: Submit history and physical, chart notes from the session(s) in which the diagnosis of gender dysphoria was determined, documentation of continuous hormone therapy, and written psychological assessment from a qualified mental health professional. For non-gender affirming surgery: Medical necessity review will be performed upon claims submission with supporting documentation.

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Code List

Code	Description	Plan Review Requirement	Reviewed For	Records Request
54520	Orchiectomy, simple (including subcapsular), with or without testicular prosthesis, scrotal or inguinal approach	Prior Authorization Required	Gender Affirming Surgery	For gender affirming surgery: Submit history and physical, chart notes from the session(s) in which the diagnosis of gender dysphoria was determined, documentation of continuous hormone therapy, and written psychological assessment from a qualified mental health professional. For non-gender affirming surgery: Medical necessity review will be performed upon claims submission with supporting documentation.
54660	Insertion of testicular prosthesis (separate procedure)	Prior Authorization Required	Gender Affirming Surgery	For gender affirming surgery: Submit history and physical, chart notes from the session(s) in which the diagnosis of gender dysphoria was determined, documentation of continuous hormone therapy, and written psychological assessment from a qualified mental health professional. For non-gender affirming surgery: Medical necessity review will be performed upon claims submission with supporting documentation.
54690	Laparoscopy, surgical; orchiectomy	Prior Authorization Required	Gender Affirming Surgery	For gender affirming surgery: Submit history and physical, chart notes from the session(s) in which the diagnosis of gender dysphoria was determined, documentation of continuous hormone therapy, and written psychological assessment from a qualified mental health professional. For non-gender affirming surgery: Medical necessity review will be performed upon claims submission with supporting documentation.

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Code List

Code	Description	Plan Review Requirement	Reviewed For	Records Request
54699	Unlisted laparoscopy procedure, testis	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical with operative/procedure report, as well as documentation to describe services
55175	Scrotoplasty; simple	Prior Authorization Required	Gender Affirming Surgery	For gender affirming surgery: Submit history and physical, chart notes from the session(s) in which the diagnosis of gender dysphoria was determined, documentation of continuous hormone therapy, and written psychological assessment from a qualified mental health professional. For non-gender affirming surgery: Medical necessity review will be performed upon claims submission with supporting documentation.
55180	Scrotoplasty; complicated	Prior Authorization Required	Gender Affirming Surgery	For gender affirming surgery: Submit history and physical, chart notes from the session(s) in which the diagnosis of gender dysphoria was determined, documentation of continuous hormone therapy, and written psychological assessment from a qualified mental health professional. For non-gender affirming surgery: Medical necessity review will be performed upon claims submission with supporting documentation.
55400	Vasovasostomy, vasovasorrhaphy	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
55559	Unlisted laparoscopy procedure, spermatic cord	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical with operative/procedure report, as well as documentation to describe services
55706	Biopsies, prostate, needle, transperineal, stereotactic template guided saturation sampling, including imaging guidance	Advance Benefit Determination (ABD) recommended	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
55866	Laparoscopy, surgical prostatectomy, retropubic radical, including nerve sparing (For open procedure, use 55840)	Prior Authorization Required	Gender Affirming Surgery	History and physical, chart notes from session(s) where gender dysphoria was determined, documentation and duration of hormone therapy; two referral letters from qualified mental health providers - one must be psychotherapist treating the member for at least 12 continuous months. Note: The prior approval request must include all surgical procedures anticipated/planned to change the member's biological gender, where the procedure(s) will be performed and the estimated date(s) for the procedures.
55880	Ablation of malignant prostate tissue, transrectal, with high intensity-focused ultrasound (HIFU), including ultrasound guidance	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history and physical, documentation of medical necessity.
55899	Unlisted procedure, male genital system	Prior Authorization Required	Gender Affirming Surgery	For gender affirming surgery: Submit history and physical, chart notes from the session(s) in which the diagnosis of gender dysphoria was determined, documentation of continuous hormone therapy, and written psychological assessment from a qualified mental health professional. For non-gender affirming surgery: Medical necessity review will be performed upon claims submission with supporting documentation.

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Code List

Code	Description	Plan Review Requirement	Reviewed For	Records Request
55970	Intersex surgery; male to female	Prior Authorization Required	Gender Affirming Surgery	For gender affirming surgery: Submit history and physical, chart notes from the session(s) in which the diagnosis of gender dysphoria was determined, documentation of continuous hormone therapy, and written psychological assessment from a qualified mental health professional. For non-gender affirming surgery: Medical necessity review will be performed upon claims submission with supporting documentation.
55980	Intersex surgery; female to male	Prior Authorization Required	Gender Affirming Surgery	For gender affirming surgery: Submit history and physical, chart notes from the session(s) in which the diagnosis of gender dysphoria was determined, documentation of continuous hormone therapy, and written psychological assessment from a qualified mental health professional. For non-gender affirming surgery: Medical necessity review will be performed upon claims submission with supporting documentation.
56620	Vulvectomy simple; partial	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, documentation of medical necessity, and operative report

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
56625	Vulvectomy simple; complete	Prior Authorization Required	Gender Affirming Surgery	For gender affirming surgery: Submit history and physical, chart notes from the session(s) in which the diagnosis of gender dysphoria was determined, documentation of continuous hormone therapy, and written psychological assessment from a qualified mental health professional. For non-gender affirming surgery: Medical necessity review will be performed upon claims submission with supporting documentation.
56800	Plastic repair of introitus	Prior Authorization Required	Gender Affirming Surgery	History and physical, chart notes from session(s) where gender dysphoria was determined, documentation and duration of hormone therapy; two referral letters from qualified mental health providers - one must be psychotherapist treating the member for at least 12 continuous months. Note: The prior approval request must include all surgical procedures anticipated/planned to change the member's biological gender, where the procedure(s) will be performed and the estimated date(s) for the procedures.

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Code List

Code	Description	Plan Review Requirement	Reviewed For	Records Request
56805	Clitoroplasty for intersex state	Prior Authorization Required	Gender Affirming Surgery	For gender affirming surgery: Submit history and physical, chart notes from the session(s) in which the diagnosis of gender dysphoria was determined, documentation of continuous hormone therapy, and written psychological assessment from a qualified mental health professional. For non-gender affirming surgery: Medical necessity review will be performed upon claims submission with supporting documentation.
57106	Vaginectomy, partial removal of vaginal wall	Prior Authorization Required	Gender Affirming Surgery	History and physical, chart notes from session(s) where gender dysphoria was determined, documentation and duration of hormone therapy; two referral letters from qualified mental health providers - one must be psychotherapist treating the member for at least 12 continuous months. Note: The prior approval request must include all surgical procedures anticipated/planned to change the member's biological gender, where the procedure(s) will be performed and the estimated date(s) for the procedures.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
57110	Vaginectomy, complete removal of vaginal wall;	Prior Authorization Required	Gender Affirming Surgery	For gender affirming surgery: Submit history and physical, chart notes from the session(s) in which the diagnosis of gender dysphoria was determined, documentation of continuous hormone therapy, and written psychological assessment from a qualified mental health professional. For non-gender affirming surgery: Medical necessity review will be performed upon claims submission with supporting documentation.
57291	Construction of artificial vagina; without graft	Prior Authorization Required	Gender Affirming Surgery	For gender affirming surgery: Submit history and physical, chart notes from the session(s) in which the diagnosis of gender dysphoria was determined, documentation of continuous hormone therapy, and written psychological assessment from a qualified mental health professional. For non-gender affirming surgery: Medical necessity review will be performed upon claims submission with supporting documentation.
57292	Construction of artificial vagina; with graft	Prior Authorization Required	Gender Affirming Surgery	For gender affirming surgery: Submit history and physical, chart notes from the session(s) in which the diagnosis of gender dysphoria was determined, documentation of continuous hormone therapy, and written psychological assessment from a qualified mental health professional. For non-gender affirming surgery: Medical necessity review will be performed upon claims submission with supporting documentation.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
57295	Revision (including removal) of prosthetic vaginal graft; vaginal approach	Prior Authorization Required	Gender Affirming Surgery	History and physical, chart notes from session(s) where gender dysphoria was determined, documentation and duration of hormone therapy; two referral letters from qualified mental health providers - one must be psychotherapist treating the member for at least 12 continuous months. Note: The prior approval request must include all surgical procedures anticipated/planned to change the member's biological gender, where the procedure(s) will be performed and the estimated date(s) for the procedures.
57296	Revision (including removal) of prosthetic vaginal graft; open abdominal approach	Prior Authorization Required	Gender Affirming Surgery	History and physical, chart notes from session(s) where gender dysphoria was determined, documentation and duration of hormone therapy; two referral letters from qualified mental health providers - one must be psychotherapist treating the member for at least 12 continuous months. Note: The prior approval request must include all surgical procedures anticipated/planned to change the member's biological gender, where the procedure(s) will be performed and the estimated date(s) for the procedures.

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Code List

Code	Description	Plan Review Requirement	Reviewed For	Records Request
57335	Vaginoplasty for intersex state	Prior Authorization Required	Gender Affirming Surgery	For gender affirming surgery: Submit history and physical, chart notes from the session(s) in which the diagnosis of gender dysphoria was determined, documentation of continuous hormone therapy, and written psychological assessment from a qualified mental health professional. For non-gender affirming surgery: Medical necessity review will be performed upon claims submission with supporting documentation.
57426	Revision (including removal) of prosthetic vaginal graft, laparoscopic approach	Prior Authorization Required	Gender Affirming Surgery	History and physical, chart notes from session(s) where gender dysphoria was determined, documentation and duration of hormone therapy; two referral letters from qualified mental health providers - one must be psychotherapist treating the member for at least 12 continuous months. Note: The prior approval request must include all surgical procedures anticipated/planned to change the member's biological gender, where the procedure(s) will be performed and the estimated date(s) for the procedures.
58150	Total abdominal hysterectomy (corpus and cervix), with or without removal of tube(s), with or without removal of ovary(s);	Prior Authorization Required	Gender Affirming Surgery	For gender affirming surgery: Submit history and physical, chart notes from the session(s) in which the diagnosis of gender dysphoria was determined, documentation of continuous hormone therapy, and written psychological assessment from a qualified mental health professional. For non-gender affirming requests, no review required.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
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	Potential Contract Exclusion	For gender affirming surgery: Submit history and physical, chart notes from the session(s) in which the diagnosis of gender dysphoria was determined, documentation of continuous hormone therapy, and written psychological assessment from a qualified mental health professional. For non-gender affirming requests, no review required.
58180	Supracervical abdominal hysterectomy (subtotal hysterectomy), with or without removal of tube(s), with or without removal of ovary(s)	Prior Authorization Required	Gender Affirming Surgery	For gender affirming surgery: Submit history and physical, chart notes from the session(s) in which the diagnosis of gender dysphoria was determined, documentation of continuous hormone therapy, and written psychological assessment from a qualified mental health professional. For non-gender affirming requests, no review required.
58200	Total abdominal hysterectomy, including partial vaginectomy, with para-aortic and pelvic lymph node sampling, with or without removal of tube(s), with or without removal of ovary(s)	Prior Authorization Required	Gender Affirming	For gender affirming surgery: Submit history and physical, chart notes from the session(s) in which the diagnosis of gender dysphoria was determined, documentation of continuous hormone therapy, and written psychological assessment from a qualified mental health professional. For non-gender affirming requests, no review required.
58260	Vaginal hysterectomy, for uterus 250 g or less;	Prior Authorization Required	Gender Affirming Surgery	For gender affirming surgery: Submit history and physical, chart notes from the session(s) in which the diagnosis of gender dysphoria was determined, documentation of continuous hormone therapy, and written psychological assessment from a qualified mental health professional. For non-gender affirming requests, no review required.

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58262	Vaginal hysterectomy, for uterus 250 g or less; with removal of tube(s), and/or ovary(s)	Prior Authorization Required	Gender Affirming Surgery	For gender affirming surgery: Submit history and physical, chart notes from the session(s) in which the diagnosis of gender dysphoria was determined, documentation of continuous hormone therapy, and written psychological assessment from a qualified mental health professional. For non-gender affirming requests, no review required.
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	Gender Affirming	For gender affirming surgery: Submit history and physical, chart notes from the session(s) in which the diagnosis of gender dysphoria was determined, documentation of continuous hormone therapy, and written psychological assessment from a qualified mental health professional. For non-gender affirming requests, no review required.
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	Gender Affirming	For gender affirming surgery: Submit history and physical, chart notes from the session(s) in which the diagnosis of gender dysphoria was determined, documentation of continuous hormone therapy, and written psychological assessment from a qualified mental health professional. For non-gender affirming requests, no review required.
58270	Vaginal hysterectomy, for uterus 250 g or less; with repair of enterocele	Prior Authorization Required	Gender Affirming	For gender affirming surgery: Submit history and physical, chart notes from the session(s) in which the diagnosis of gender dysphoria was determined, documentation of continuous hormone therapy, and written psychological assessment from a qualified mental health professional. For non-gender affirming requests, no review required.

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58275	Vaginal hysterectomy, with total or partial vaginectomy;	Prior Authorization Required	Gender Affirming Surgery	For gender affirming surgery: Submit history and physical, chart notes from the session(s) in which the diagnosis of gender dysphoria was determined, documentation of continuous hormone therapy, and written psychological assessment from a qualified mental health professional. For non-gender affirming requests, no review required.
58280	Vaginal hysterectomy, with total or partial vaginectomy; with repair of enterocele	Prior Authorization Required	Gender Affirming	For gender affirming surgery: Submit history and physical, chart notes from the session(s) in which the diagnosis of gender dysphoria was determined, documentation of continuous hormone therapy, and written psychological assessment from a qualified mental health professional. For non-gender affirming requests, no review required.
58290	Vaginal hysterectomy, for uterus greater than 250 grams;	Prior Authorization Required	Gender Affirming	For gender affirming surgery: Submit history and physical, chart notes from the session(s) in which the diagnosis of gender dysphoria was determined, documentation of continuous hormone therapy, and written psychological assessment from a qualified mental health professional. For non-gender affirming requests, no review required.
58291	Vaginal hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)	Prior Authorization Required	Gender Affirming	For gender affirming surgery: Submit history and physical, chart notes from the session(s) in which the diagnosis of gender dysphoria was determined, documentation of continuous hormone therapy, and written psychological assessment from a qualified mental health professional. For non-gender affirming requests, no review required.

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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	Gender Affirming	For gender affirming surgery: Submit history and physical, chart notes from the session(s) in which the diagnosis of gender dysphoria was determined, documentation of continuous hormone therapy, and written psychological assessment from a qualified mental health professional. For non-gender affirming requests, no review required.
58294	Vaginal hysterectomy, for uterus greater than 250 g; with repair of enterocele	Prior Authorization Required	Gender Affirming	For gender affirming surgery: Submit history and physical, chart notes from the session(s) in which the diagnosis of gender dysphoria was determined, documentation of continuous hormone therapy, and written psychological assessment from a qualified mental health professional. For non-gender affirming requests, no review required.
58321	Artificial insemination; intra-cervical	Prior Authorization Required	Potential Contract Exclusion	History and physical, and documentation of infertility, including treatment plan
58322	Artificial insemination; intra-uterine	Prior Authorization Required	Potential Contract Exclusion	History and physical, documentation of infertility, including treatment plan
58323	Sperm washing for artificial insemination	Non-covered Service	Not Covered	Considered non-covered when identified as IVF service and unless member's contract indicates coverage.

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58541	Laparoscopy, surgical, supracervical hysterectomy, for uterus 250 g or less;	Prior Authorization Required	Gender Affirming Surgery	For gender affirming surgery: Submit history and physical, chart notes from the session(s) in which the diagnosis of gender dysphoria was determined, documentation of continuous hormone therapy, and written psychological assessment from a qualified mental health professional. For non-gender affirming surgery: Medical necessity review will be performed upon claims submission with supporting documentation. For non-gender affirming requests, no review required.
58542	Laparoscopy, surgical, supracervical hysterectomy, for uterus 250 g or less; with removal of tube(s) and/or ovary(s)	Prior Authorization Required	Gender Affirming Surgery	For gender affirming surgery: Submit history and physical, chart notes from the session(s) in which the diagnosis of gender dysphoria was determined, documentation of continuous hormone therapy, and written psychological assessment from a qualified mental health professional. For non-gender affirming surgery: Medical necessity review will be performed upon claims submission with supporting documentation. For non-gender affirming requests, no review required.

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58543	Laparoscopy, surgical, supracervical hysterectomy, for uterus greater than 250 g;	Prior Authorization Required	Gender Affirming Surgery	For gender affirming surgery: Submit history and physical, chart notes from the session(s) in which the diagnosis of gender dysphoria was determined, documentation of continuous hormone therapy, and written psychological assessment from a qualified mental health professional. For non-gender affirming surgery: Medical necessity review will be performed upon claims submission with supporting documentation. For non-gender affirming requests, no review required.
58544	Laparoscopy, surgical, supracervical hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)	Prior Authorization Required	Gender Affirming Surgery	For gender affirming surgery: Submit history and physical, chart notes from the session(s) in which the diagnosis of gender dysphoria was determined, documentation of continuous hormone therapy, and written psychological assessment from a qualified mental health professional. For non-gender affirming surgery: Medical necessity review will be performed upon claims submission with supporting documentation. For non-gender affirming requests, no review required.

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58550	Laparoscopy, surgical, with vaginal hysterectomy, for uterus 250 g or less;	Prior Authorization Required	Gender Affirming Surgery	For gender affirming surgery: Submit history and physical, chart notes from the session(s) in which the diagnosis of gender dysphoria was determined, documentation of continuous hormone therapy, and written psychological assessment from a qualified mental health professional. For non-gender affirming surgery: Medical necessity review will be performed upon claims submission with supporting documentation. For non-gender affirming requests, no review required.
58552	Laparoscopy, surgical, with vaginal hysterectomy, for uterus 250 g or less; with removal of tube(s) and/or ovary(s)	Prior Authorization Required	Gender Affirming Surgery	For gender affirming surgery: Submit history and physical, chart notes from the session(s) in which the diagnosis of gender dysphoria was determined, documentation of continuous hormone therapy, and written psychological assessment from a qualified mental health professional. For non-gender affirming surgery: Medical necessity review will be performed upon claims submission with supporting documentation. For non-gender affirming requests, no review required.

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58553	Laparoscopy, surgical, with vaginal hysterectomy, for uterus greater than 250 grams	Prior Authorization Required	Gender Affirming Surgery	For gender affirming surgery: Submit history and physical, chart notes from the session(s) in which the diagnosis of gender dysphoria was determined, documentation of continuous hormone therapy, and written psychological assessment from a qualified mental health professional. For non-gender affirming surgery: Medical necessity review will be performed upon claims submission with supporting documentation. For non-gender affirming requests, no review required.
58554	Laparoscopy, surgical, with vaginal hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)	Prior Authorization Required	Gender Affirming Surgery	For gender affirming surgery: Submit history and physical, chart notes from the session(s) in which the diagnosis of gender dysphoria was determined, documentation of continuous hormone therapy, and written psychological assessment from a qualified mental health professional. For non-gender affirming surgery: Medical necessity review will be performed upon claims submission with supporting documentation. For non-gender affirming requests, no review required.
58570	Laparoscopy, surgical, with total hysterectomy, for uterus 250 g or less;	Prior Authorization Required	Gender Affirming Surgery	For gender affirming surgery: Submit history and physical, chart notes from the session(s) in which the diagnosis of gender dysphoria was determined, documentation of continuous hormone therapy, and written psychological assessment from a qualified mental health professional. For non-gender affirming requests, no review required.

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58571	Laparoscopy, surgical, with total hysterectomy, for uterus 250 g or less; with removal of tube(s) and/or ovary(s)	Prior Authorization Required	Gender Affirming Surgery	For gender affirming surgery: Submit history and physical, chart notes from the session(s) in which the diagnosis of gender dysphoria was determined, documentation of continuous hormone therapy, and written psychological assessment from a qualified mental health professional. For non-gender affirming requests, no review required.
58572	Laparoscopy, surgical, with total hysterectomy, for uterus greater than 250 g;	Prior Authorization Required	Gender Affirming Surgery	For gender affirming surgery: Submit history and physical, chart notes from the session(s) in which the diagnosis of gender dysphoria was determined, documentation of continuous hormone therapy, and written psychological assessment from a qualified mental health professional. For non-gender affirming requests, no review required.
58573	Laparoscopy, surgical, with total hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)	Prior Authorization Required	Gender Affirming Surgery	For gender affirming surgery: Submit history and physical, chart notes from the session(s) in which the diagnosis of gender dysphoria was determined, documentation of continuous hormone therapy, and written psychological assessment from a qualified mental health professional. For non-gender affirming requests, no review required.
58578	Unlisted laparoscopy procedure, uterus	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical with operative/procedure report, as well as documentation to describe services
58579	Unlisted hysteroscopy procedure, uterus	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical with operative/procedure report, as well as documentation to describe services
58580	Transcervical ablation of uterine fibroid(s), including intraoperative ultrasound guidance and monitoring, radiofrequency	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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58661	Laparoscopy, surgical; with removal of adnexal structures (partial or total oophorectomy and/or salpingectomy)	Prior Authorization Required	Gender Affirming Surgery	For gender affirming surgery: Submit history and physical, chart notes from the session(s) in which the diagnosis of gender dysphoria was determined, documentation of continuous hormone therapy, and written psychological assessment from a qualified mental health professional. For non-gender affirming requests, no review required.
58674	Laparoscopy, surgical, ablation of uterine fibroid(s) including intraoperative ultrasound guidance and monitoring, radiofrequency	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history and physical, documentation of medical necessity and procedure report.
58679	Unlisted laparoscopy procedure, oviduct, ovary	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical with operative/procedure report, as well as documentation to describe services
58720	Salpingo-oophorectomy, complete or partial, unilateral or bilateral (separate procedure)	Prior Authorization Required	Gender Affirming Surgery	For gender affirming surgery: Submit history and physical, chart notes from the session(s) in which the diagnosis of gender dysphoria was determined, documentation of continuous hormone therapy, and written psychological assessment from a qualified mental health professional. For non-gender affirming surgery: Medical necessity review will be performed upon claims submission with supporting documentation.
58750	Tubotubal anastomosis	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, pre-operative evaluation, treatment plan, and diagnostic test results
58970	Follicle puncture for oocyte retrieval, any method	Prior Authorization Required	Potential Contract Exclusion	History and physical, and documentation of infertility, including treatment plan
58974	Embryo transfer, intrauterine	Prior Authorization Required	Potential Contract Exclusion	History and physical, and documentation of infertility, including treatment plan

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58976	Gamete, zygote, or embryo intrafallopian transfer, any method	Non-covered Service	Not Covered	Considered non-covered when identified as IVF service and unless member's contract indicates coverage.
58999	Unlisted procedure, female genital system (nonobstetrical)	Prior Authorization Required	Gender Affirming Surgery	For gender affirming surgery: Submit history and physical, chart notes from the session(s) in which the diagnosis of gender dysphoria was determined, documentation of continuous hormone therapy, and written psychological assessment from a qualified mental health professional. For non-gender affirming surgery: Medical necessity review will be performed upon claims submission with supporting documentation.
59840	Induced abortion, by dilation and curettage	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
59841	Induced abortion, by dilation and evacuation	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
59850	Induced abortion, by 1 or more intra-amniotic injections (amniocentesis-injections), including hospital admission and visits, delivery of fetus and secundines	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
59851	Induced abortion, by 1 or more intra-amniotic injections (amniocentesis-injections), including hospital admission and visits, delivery of fetus and secundines; with dilation and curettage and/or evacuation	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
59852	Induced abortion, by 1 or more intra-amniotic injections (amniocentesis-injections), including hospital admission and visits, delivery of fetus and secundines; with hysterotomy (failed intra-amniotic injection)	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.

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59855	Induced abortion, by 1 or more vaginal suppositories (eg, prostaglandin) with or without cervical dilation (eg, laminaria), including hospital admission and visits, delivery of fetus and secundines	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
59856	Induced abortion, by 1 or more vaginal suppositories (eg, prostaglandin) with or without cervical dilation (eg, laminaria), including hospital admission and visits, delivery of fetus and secundines; with dilation and curettage and/or evacuation	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
59857	Induced abortion, by 1 or more vaginal suppositories (eg, prostaglandin) with or without cervical dilation (eg, laminaria), including hospital admission and visits, delivery of fetus and secundines; with hysterotomy (failed medical evacuation)	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
59866	Multifetal pregnancy reduction(s) (MPR)	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
59897	Unlisted fetal invasive procedure, including ultrasound guidance, when performed	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, and documentation of medical necessity, with operative/procedure report, as well as documentation to describe services
59898	Unlisted laparoscopy procedure, maternity care and delivery	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical with operative/procedure report, as well as documentation to describe services
59899	Unlisted procedure, maternity care and delivery	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical with operative/procedure report, as well as documentation to describe services
60659	Unlisted laparoscopy procedure, endocrine system	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical with operative/procedure report, as well as documentation to describe services
60660	Ablation of 1 or more thyroid nodule(s), one lobe or the isthmus, percutaneous, including imaging guidance, radiofrequency	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	Submit history,physical and operative report

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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)	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	Submit history,physical and operative report
60699	Unlisted procedure, endocrine system	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical with operative/procedure report, as well as documentation to describe services
61613	Obliteration of carotid aneurysm, arteriovenous malformation, or carotid-cavernous fistula by dissection within cavernous sinus	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history,physical and operative report
61680	Surgery of intracranial arteriovenous malformation; supratentorial, simple	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history,physical and operative report
61682	Surgery of intracranial arteriovenous malformation; supratentorial, complex	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history,physical and operative report
61684	Surgery of intracranial arteriovenous malformation; infratentorial, simple	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history,physical and operative report
61686	Surgery of intracranial arteriovenous malformation; infratentorial, complex	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history,physical and operative report
61690	Surgery of intracranial arteriovenous malformation; dural, simple	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history,physical and operative report
61692	Surgery of intracranial arteriovenous malformation; dural, complex	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history,physical and operative report
61705	Surgery of aneurysm, vascular malformation or carotid-cavernous fistula; by intracranial and cervical occlusion of carotid artery	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and Physical, documentation of medical necessity
61708	Surgery of aneurysm, vascular malformation or carotid-cavernous fistula; by intracranial electrothrombosis	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history,physical and operative report
61710	Surgery of aneurysm, vascular malformation or carotid-cavernous fistula; by intra-arterial embolization, injection procedure, or balloon catheter	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and Physical, documentation of medical necessity

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61715	Magnetic resonance image guided high intensity focused ultrasound (MRgFUS), stereotactic ablation of target, intracranial, including stereotactic navigation and frame placement, when performed	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	Submit history,physical and operative report
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	Medical necessity review will be performed upon claims submission with supporting documentation	Investigative	Submit procedure/testing report
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)	Medical necessity review will be performed upon claims submission with supporting documentation	Investigative	Submit procedure/testing report
62281	Injection/infusion of neurolytic substance (eg, alcohol, phenol, iced saline solutions), with or without other therapeutic substance; epidural, cervical or thoracic	Advance Benefit Determination (ABD) recommended	Investigative	Submit history and physical, documentation of medical necessity and procedure report.
62287	Decompression procedure, percutaneous, of nucleus pulposus of intervertebral disc, any method, single or multiple levels, lumbar	Advance Benefit Determination (ABD) recommended	Investigative	Submit procedure/testing report
62292	Injection procedure for chemonucleolysis, including discography, intervertebral disc, single or multiple levels, lumbar	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history and physical, documentation of medical necessity.
62330	Decompression, percutaneous, with partial removal of ligamentum flavum, including laminotomy for access, epidurography, and imaging guidance (i.e., CT or fluoroscopy), bilateral; on interspace, lumbar	Retrospective Review	Medical Necessity	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, treatment history, operative report and anesthesia report

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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	Advance Benefit Determination (ABD) recommended	Investigative	Submit history,physical and operative report
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	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, conservative measures, operative report, and anesthesia report
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	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, conservative measures, operative report, and anesthesia report
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	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, conservative measures, operative report, and anesthesia report
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	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, conservative measures, operative report, and anesthesia report
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	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, conservative measures, operative report, and anesthesia report

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Code List

Code	Description	Plan Review Requirement	Reviewed For	Records Request
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	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, conservative measures, operative report, and anesthesia report
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	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, conservative measures, operative report, and anesthesia report
63032	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and excision of herniated intervertebral disc; with repair of annular defect by implantation of bone-anchored annular closure device, including all imaging guidance, 1 interspace, lumbar (list separately in addition to code for primary procedure)	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, conservative measures, operative report, and anesthesia report
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	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, conservative measures, operative report, and anesthesia report
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	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, conservative measures, operative report, and anesthesia report

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Code List

Code	Description	Plan Review Requirement	Reviewed For	Records Request
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	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, conservative measures, operative report, and anesthesia report
63043	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc, re-exploration, single interspace; each additional cervical interspace (List separately in addition to code for primary procedure)	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, conservative measures, operative report, and anesthesia report
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	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, conservative measures, operative report, and anesthesia report
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	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, conservative measures, operative report, and anesthesia report
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	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, conservative measures, operative report, and anesthesia report

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Code List

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	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, conservative measures, operative report, and anesthesia report
63050	Laminoplasty, cervical, with decompression of the spinal cord, 2 or more vertebral segments;	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, conservative measures, operative report, and anesthesia report
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	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, conservative measures, operative report, and anesthesia report
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	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, conservative measures, operative report, and anesthesia report

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Code List

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	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, conservative measures, operative report, and anesthesia 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	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, conservative measures, operative report, and anesthesia report
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	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, conservative measures, operative report, and anesthesia report
63075	Discectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophytectomy; cervical, single interspace	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, conservative measures, operative report, and anesthesia report
63076	Discectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophytectomy; cervical, each additional interspace (List separately in addition to code for primary procedure)	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, conservative measures, operative report, and anesthesia report

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Code List

Code	Description	Plan Review Requirement	Reviewed For	Records Request
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	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, conservative measures, operative report, and anesthesia report
63185	Laminectomy with rhizotomy; 1 or 2 segments	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, conservative measures, operative report, and anesthesia report
63190	Laminectomy with rhizotomy; more than 2 segments	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, conservative measures, operative report, and anesthesia report
63191	Laminectomy with section of spinal accessory nerve	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, conservative measures, operative report, and anesthesia report
63200	Laminectomy, with release of tethered spinal cord, lumbar	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, conservative measures, operative report, and anesthesia report
63250	Laminectomy for excision or occlusion of arteriovenous malformation of spinal cord; cervical	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history,physical and operative report
63251	Laminectomy for excision or occlusion of arteriovenous malformation of spinal cord; thoracic	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history,physical and operative report
63252	Laminectomy for excision or occlusion of arteriovenous malformation of spinal cord; thoracolumbar	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history,physical and operative report

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Code List

Code	Description	Plan Review Requirement	Reviewed For	Records Request
63265	Laminectomy for excision or evacuation of intraspinal lesion other than neoplasm, extradural; cervical	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, conservative measures, operative report, and anesthesia report
63267	Laminectomy for excision or evacuation of intraspinal lesion other than neoplasm, extradural; lumbar	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, conservative measures, operative report, and anesthesia report
63272	Laminectomy for excision of intraspinal lesion other than neoplasm, intradural; lumbar	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, conservative measures, operative report, and anesthesia report
63285	Laminectomy for biopsy/excision of intraspinal neoplasm; intradural, intramedullary, cervical	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, imaging reports and operative/procedure report
63650	Percutaneous implantation of neurostimulator electrode array, epidural	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, and pre-operative evaluation(s), including clearance by a licensed mental health professional, and operative report
63655	Laminectomy for implantation of neurostimulator electrodes, plate/paddle, epidural	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, and pre-operative evaluation(s), including clearance by a licensed mental health professional, and operative report
63685	Insertion or replacement of spinal neurostimulator pulse generator or receiver, requiring pocket creation and connection between electrode array and pulse generator receiver	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and Physical, documentation of medical necessity
63688	Revision or removal of implanted spinal neurostimulator pulse generator or receiver, with detachable connection to electrode array	Pre-Service Review Required	Medical Necessity Review Required	History and physical, documentation of medical necessity, and operative report
64505	Injection, anesthetic agent; sphenopalatine ganglion	Advance Benefit Determination (ABD) recommended	Investigative	Submit procedure/testing report

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Code List

Code	Description	Plan Review Requirement	Reviewed For	Records Request
64553	Percutaneous implantation of neurostimulator electrodes; cranial nerve	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, pre-operative evaluation, and operative report
64555	Percutaneous implantation of neurostimulator electrodes; peripheral nerve (excludes sacral nerve)	Advance Benefit Determination (ABD) recommended	Investigative	History and physical, and procedure report. medical necessity review will be performed upon claims submission with supporting documentation
64561	Percutaneous implantation of neurostimulator electrodes sacral nerve (transforaminal placement)	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, pre-operative evaluation, and operative report
64568	Incision for implantation of cranial nerve (eg, vagus nerve) neurostimulator electrode array and pulse generator	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, pre-operative evaluation, and operative report
64569	Revision or replacement of cranial nerve (eg, vagus nerve) neurostimulator electrode array, including connection to existing pulse generator	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and Physical, clinical notes related to a condition being treated, documentation of previous therapies tried and failed.
64575	Incision for implantation of neurostimulator electrode array; peripheral nerve (excludes sacral nerve)	Advance Benefit Determination (ABD) recommended	Investigative	Submit procedure report. medical necessity review will be performed upon claims submission with supporting documentation
64581	Incision of implantation of neurostimulator electrodes sacral nerve (transforaminal placement)	Advance Benefit Determination (ABD) recommended	Medical Necessity	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	Advance Benefit Determination (ABD) recommended	Medical Necessity	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	Advance Benefit Determination (ABD) recommended	Medical Necessity	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	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history and physical, documentation of medical necessity.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
64585	Revision or removal of peripheral neurostimulator electrode array	Advance Benefit Determination (ABD) recommended	Investigative	Submit History and Physical, documentation of medical necessity. medical necessity review will be performed upon claims submission with supporting documentation
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	Advance Benefit Determination (ABD) recommended	Investigative	History and physical, and procedure report. medical necessity review will be performed upon claims submission with supporting documentation
64595	Revision or removal of peripheral, sacral, or gastric neurostimulator pulse generator or receiver, with detachable connection to electrode array	Advance Benefit Determination (ABD) recommended	Investigative	History and physical, and procedure report. medical necessity review will be performed upon claims submission with supporting documentation
64600	Destruction by neurolytic agent, trigeminal nerve; supraorbital, infraorbital, mental, or inferior alveolar branch	Advance Benefit Determination (ABD) recommended	Investigative	Submit history and physical, documentation of medical necessity and procedure report.
64611	Chemodenervation of parotid and submandibular salivary glands, bilateral	Pre-Service Review Required	Medical Necessity Review Required	History and physical, documentation of medical necessity, and operative report
64615	Chemodenervation of muscle(s); muscle(s) innervated by facial, trigeminal, cervical spinal and accessory nerves, bilateral (eg, for chronic migraine)	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history and physical, documentation of medical necessity and procedure report.
64624	Destruction by neurolytic agent, genicular nerve branches including imaging guidance, when performed	Advance Benefit Determination (ABD) recommended	Investigative	History and Physical, documentation of medical necessity
64625	Radiofrequency ablation, nerves innervating the sacroiliac joint, with image guidance (ie, fluoroscopy or computed tomography)	Advance Benefit Determination (ABD) recommended	Investigative	Submit history and physical, documentation of medical necessity and procedure report.
64628	Thermal destruction of intraosseous basivertebral nerve, including all imaging guidance; first 2 vertebral bodies, lumbar or sacral	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
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)	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	Submit history and physical, documentation of medical necessity.
64632	Destruction by neurolytic agent; plantar common digital nerve	Advance Benefit Determination (ABD) recommended	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	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, imaging reports, documentation of conservative measures, and two diagnostic medial branch block procedure reports with response, as well as procedure report for the service under review
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)	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, imaging reports, documentation of conservative measures, and two diagnostic medial branch block procedure reports with response, as well as procedure report for the service under review
64635	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); lumbar or sacral, single facet joint	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, documentation of medical necessity, treatment plan
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)	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, documentation of medical necessity, treatment plan
64640	Destruction by neurolytic agent; other peripheral nerve or branch	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, operative report and documentation of conservative measures

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
64721	Neuroplasty and/or transposition; median nerve at carpal tunnel	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, pre-op evaluations, imaging reports, conservative measures and response, operative/procedure report, anesthesia report, and documentation of medical necessity
64912	Nerve repair; with nerve allograft, each nerve, first strand (cable)	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and Physical, documentation of medical necessity
64913	Nerve repair; with nerve allograft, each additional strand (List separately in addition to code for primary procedure)	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, pre-operative evaluation, and operative report
64999	Unlisted procedure, nervous system	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, pre-op evaluation(s), imaging reports, conservative measures and response, operative/procedure report, anesthesia report, documentation of medical necessity, and description of services
65760	Keratomileusis	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
65771	Radial keratotomy	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
65778	Placement of amniotic membrane on the ocular surface; without sutures	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history and physical, documentation of medical necessity.
65779	Placement of amniotic membrane on the ocular surface; single layer, sutured	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history and physical, documentation of medical necessity.
65785	Implantation of intrastromal corneal ring segments	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
66999	Unlisted procedure of the eye	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical with operative/procedure report, as well as documentation to describe services
67299	Unlisted procedure, posterior segment	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical with operative/procedure report, as well as documentation to describe services
67399	Unlisted procedure, ocular muscle	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical with operative/procedure report, as well as documentation to describe services

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
67599	Unlisted procedure, orbit	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical with operative/procedure report, as well as documentation to describe services
67900	Repair of brow ptosis (supraciliary, mid-forehead or coronal approach)	Advance Benefit Determination (ABD) recommended	Potential Contract Exclusion	For gender affirming surgery: Submit history and physical, documentation of gender dysphoria and any hormone therapy, as well as written psychological assessment from a qualified mental health provider. For non-gender affirming surgery: Submit history and physical, pre-operative evaluation, including functional impairment and operative report. Medical necessity review will be performed upon claims submission with supporting documentation
67901	Repair of blepharoptosis; frontalis muscle technique with suture or other material (eg, banked fascia)	Advance Benefit Determination (ABD) recommended	Potential Contract Exclusion	History and physical, pre-operative evaluation, including functional impairment, operative report, and photos. For non-gender affirming surgery: Medical necessity review will be performed upon claims submission with supporting documentation.
67902	Repair of blepharoptosis; frontalis muscle technique with autologous fascial sling (includes obtaining fascia)	Advance Benefit Determination (ABD) recommended	Potential Contract Exclusion	History and physical, pre-operative evaluation, including functional impairment, operative report, and photos.For non-gender affirming surgery: Medical necessity review will be performed upon claims submission with supporting documentation.
67903	Repair of blepharoptosis; (tarso) levator resection or advancement, internal approach	Advance Benefit Determination (ABD) recommended	Potential Contract Exclusion	History and physical, documentation of medical necessity, treatment plan

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
67904	Repair of blepharoptosis; (tarso) levator resection or advancement, external approach	Advance Benefit Determination (ABD) recommended	Potential Contract Exclusion	History and physical, pre-operative evaluation, including functional impairment, operative report, and photos.For non-gender affirming surgery: Medical necessity review will be performed upon claims submission with supporting documentation.
67906	Repair of blepharoptosis; superior rectus technique with fascial sling (includes obtaining fascia)	Advance Benefit Determination (ABD) recommended	Potential Contract Exclusion	Submit History and Physical, documentation of medical necessity.For non-gender affirming surgery: Medical necessity review will be performed upon claims submission with supporting documentation.
67908	Repair of blepharoptosis; conjunctivo-tarso-Muller's muscle-levator resection (eg, Fasanella-Servat type)	Advance Benefit Determination (ABD) recommended	Potential Contract Exclusion	History and physical, pre-operative evaluation, including functional impairment, operative report, and photos.For non-gender affirming surgery: Medical necessity review will be performed upon claims submission with supporting documentation.
67914	Repair of ectropion; suture	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, documentation of medical necessity, and photographs
67950	Canthoplasty (reconstruction of canthus)	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, documentation of medical necessity, and photographs
67971	Reconstruction of eyelid, full thickness by transfer of tarsoconjunctival flap from opposing eyelid; up to two-thirds of eyelid, 1 stage or first stage	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, visual impairment, and pre-op evaluations
67973	Reconstruction of eyelid, full thickness by transfer of tarsoconjunctival flap from opposing eyelid; total eyelid, lower, 1 stage or first stage	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, visual impairment, and pre-op evaluations
67974	Reconstruction of eyelid, full thickness by transfer of tarsoconjunctival flap from opposing eyelid; total eyelid, upper, 1 stage or first stage	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, visual impairment, and pre-op evaluations

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67975	Reconstruction of eyelid, full thickness by transfer of tarsoconjunctival flap from opposing eyelid; second stage	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, visual impairment, and pre-op evaluations
67999	Unlisted procedure, eyelids	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and Physical, documentation of medical necessity
68399	Unlisted procedure, conjunctiva	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and Physical, documentation of medical necessity
68899	Unlisted procedure, lacrimal system	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical with operative/procedure report, as well as documentation to describe services
69090	Ear piercing	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
69300	Otoplasty, protruding ear, with or without size reduction	Advance Benefit Determination (ABD) recommended	Potential Contract Exclusion	For gender affirming surgery: Submit history and physical, documentation of gender dysphoria and any hormone therapy, as well as written psychological assessment from a qualified mental health provider. For non-gender affirming surgery: Submit history and physical, pre-operative evaluation, including functional impairment and operative report. Medical necessity review will be performed upon claims submission with supporting documentation
69310	Reconstruction of external auditory canal (meatoplasty) (eg, for stenosis due to injury, infection) (separate procedure)	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, visual impairment, and pre-op evaluations
69320	Reconstruction external auditory canal for congenital atresia, single stage	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history,physical and operative report
69399	Unlisted procedure, external ear	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical with operative/procedure report, as well as documentation to describe services

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69641	Tympanoplasty with mastoidectomy (including canalplasty, middle ear surgery, tympanic membrane repair); without ossicular chain reconstruction	Prior Authorization Required	Medical Necessity	History and Physical, documentation of medical necessity
69642	Tympanoplasty with mastoidectomy (including canalplasty, middle ear surgery, tympanic membrane repair); with ossicular chain reconstruction	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, visual impairment, and pre-op evaluations
69643	Tympanoplasty with mastoidectomy (including canalplasty, middle ear surgery, tympanic membrane repair); with intact or reconstructed wall, without ossicular chain reconstruction	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, visual impairment, and pre-op evaluations
69644	Tympanoplasty with mastoidectomy (including canalplasty, middle ear surgery, tympanic membrane repair); with intact or reconstructed canal wall, with ossicular chain reconstruction	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, visual impairment, and pre-op evaluations
69646	Chemodenervation of trunk muscle(s); 1-5 muscle(s)	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, visual impairment, and pre-op evaluations
69705	Nasopharyngoscopy, surgical, with dilation of eustachian tube (ie, balloon dilation); unilateral	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history and physical, documentation of medical necessity.
69706	Nasopharyngoscopy, surgical, with dilation of eustachian tube (ie, balloon dilation); bilateral	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history and physical, documentation of medical necessity.
69710	Implantation or replacement of electromagnetic bone conduction hearing device in temporal bone	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
69711	Removal or repair of electromagnetic bone conduction hearing device in temporal bone	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.

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Code List

Code	Description	Plan Review Requirement	Reviewed For	Records Request
69714	Implantation, osseointegrated implant, temporal bone, with percutaneous attachment to external speech processor/cochlear stimulator; without mastoidectomy	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
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	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
69717	Replacement (including removal of existing device), osseointegrated implant, skull; with percutaneous attachment to external speech processor	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
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	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
69728	Removal, entire osseointegrated implant, skull; with magnetic transcutaneous attachment to external speech processor, outside the mastoid and involving a bony defect greater than or equal to 100 sq mm surface area of bone deep to the outer cranial cortex	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.

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Code List

Code	Description	Plan Review Requirement	Reviewed For	Records Request
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	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
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	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
69799	Unlisted procedure, middle ear	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and Physical, documentation of medical necessity
69930	Cochlear device implantation, with or without mastoidectomy	Prior Authorization Required	Medical Necessity	History and physical, operative report, and audiology report with hearing thresholds. medical necessity review will be performed upon claims submission with supporting documentation
69949	Unlisted procedure, inner ear	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical with operative/procedure report, as well as documentation to describe services
69979	Unlisted procedure, temporal bone, middle fossa approach	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and Physical, documentation of medical necessity NOTE: Claims for this drug are processed through the Local Plan, not pharmacy.
70336	Magnetic resonance (eg, proton) imaging, temporomandibular joint(s)	Prior Authorization Required	Medical Necessity	History and Physical, documentation of medical necessity
70450	Computed tomography, head or brain; without contrast material	Prior Authorization Required	Medical Necessity	History and Physical, documentation of medical necessity
70460	Computed tomography, head or brain; with contrast material(s)	Prior Authorization Required	Medical Necessity	History and Physical, documentation of medical necessity

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70470	Computed tomography, head or brain; without contrast material, followed by contrast material(s) and further sections	Prior Authorization Required	Medical Necessity	History and Physical, documentation of medical necessity
70472	Computed tomographic (CT) cerebral perfusion analysis with contrast material(s), including image postprocessing performed with concurrent CT or CT angiography of the same anatomy (List separately in addition to code for primary procedure)	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity and applicable imaging report(s)
70473	Computed tomographic (CT) cerebral perfusion analysis with contrast material(s), including image postprocessing performed without concurrent CT or CT angiography of the same anatomy	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity and applicable imaging report(s)
70480	Computed tomography, orbit, sella, or posterior fossa or outer, middle, or inner ear; without contrast material	Prior Authorization Required	Medical Necessity	History and Physical, documentation of medical necessity
70481	Computed tomography, orbit, sella, or posterior fossa or outer, middle, or inner ear; with contrast material(s)	Prior Authorization Required	Medical Necessity	History and Physical, documentation of medical necessity
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	Medical Necessity	History and Physical, documentation of medical necessity
70486	Computed tomography, maxillofacial area; without contrast material	Prior Authorization Required	Medical Necessity	History and Physical, documentation of medical necessity
70487	Computed tomography, maxillofacial area; with contrast material(s)	Prior Authorization Required	Medical Necessity	History and Physical, documentation of medical necessity
70488	Computed tomography, maxillofacial area; without contrast material, followed by contrast material(s) and further sections	Prior Authorization Required	Medical Necessity	History and Physical, documentation of medical necessity
70490	Computed tomography, soft tissue neck; without contrast material	Prior Authorization Required	Medical Necessity	History and Physical, documentation of medical necessity

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Code List

Code	Description	Plan Review Requirement	Reviewed For	Records Request
70491	Computed tomography, soft tissue neck; with contrast material(s)	Prior Authorization Required	Medical Necessity	History and Physical, documentation of medical necessity
70492	Computed tomography, soft tissue neck; without contrast material followed by contrast material(s) and further sections	Prior Authorization Required	Medical Necessity	History and Physical, documentation of medical necessity
70496	Computed tomographic angiography, head, with contrast material(s), including noncontrast images, if performed, and image postprocessing	Prior Authorization Required	Medical Necessity	History and Physical, documentation of medical necessity
70498	Computed tomographic angiography, neck, with contrast material(s), including noncontrast images, if performed, and image postprocessing	Prior Authorization Required	Medical Necessity	History and Physical, documentation of medical necessity
70540	Magnetic resonance (eg, proton) imaging, orbit, face, and/or neck; without contrast material(s)	Prior Authorization Required	Medical Necessity	History and Physical, documentation of medical necessity
70542	Magnetic resonance (eg, proton) imaging, orbit, face, and/or neck; with contrast material(s)	Prior Authorization Required	Medical Necessity	History and Physical, documentation of medical necessity
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	Medical Necessity	History and Physical, documentation of medical necessity
70544	Magnetic resonance angiography, head; without contrast material(s)	Prior Authorization Required	Medical Necessity	History and Physical, documentation of medical necessity
70545	MRA head; with contrast	Prior Authorization Required	Medical Necessity	History and Physical, documentation of medical necessity
70546	Magnetic resonance angiography, head; without contrast material(s), followed by contrast material(s) and further sequences	Prior Authorization Required	Medical Necessity	History and Physical, documentation of medical necessity
70547	Magnetic resonance angiography, neck; without contrast material(s)	Prior Authorization Required	Medical Necessity	History and Physical, documentation of medical necessity
70548	Magnetic resonance angiography, neck; with contrast material(s)	Prior Authorization Required	Medical Necessity	History and Physical, documentation of medical necessity

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Code List

Code	Description	Plan Review Requirement	Reviewed For	Records Request
70549	Magnetic resonance angiography, neck; without contrast material(s), followed by contrast material(s) and further sequences	Prior Authorization Required	Medical Necessity	History and Physical, documentation of medical necessity
70551	Magnetic resonance (eg, proton) imaging, brain (including brain stem); without contrast material	Prior Authorization Required	Medical Necessity	History and Physical, documentation of medical necessity
70552	Magnetic resonance (eg, proton) imaging, brain (including brain stem); with contrast material(s)	Prior Authorization Required	Medical Necessity	History and Physical, documentation of medical necessity
70553	Magnetic resonance (eg, proton) imaging, brain (including brain stem); without contrast material, followed by contrast material(s) and further sequences	Prior Authorization Required	Medical Necessity	History and Physical, documentation of medical necessity
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	Medical Necessity	Submit history and physical and documentation of medical necessity, and procedure/imaging report
70555	Magnetic resonance imaging, brain, functional MRI; requiring physician or psychologist administration of entire neurofunctional testing	Prior Authorization Required	Medical Necessity	Submit history and physical and documentation of medical necessity, and procedure/imaging report
70557	Magnetic resonance (eg, proton) imaging, brain (including brain stem and skull base), during open intracranial procedure (eg, to assess for residual tumor or residual vascular malformation); without contrast material	Prior Authorization Required	Medical Necessity	Submit history and physical and documentation of medical necessity, and procedure/imaging report
70558	Magnetic resonance (eg, proton) imaging, brain (including brain stem and skull base), during open intracranial procedure (eg, to assess for residual tumor or residual vascular malformation); with contrast material(s)	Prior Authorization Required	Medical Necessity	History and Physical, documentation of medical necessity

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Code List

Code	Description	Plan Review Requirement	Reviewed For	Records Request
70559	Magnetic resonance (eg, proton) imaging, brain (including brain stem and skull base), during open intracranial procedure (eg, to assess for residual tumor or residual vascular malformation); without contrast material(s), followed by contrast material(s) and further sequences	Prior Authorization Required	Medical Necessity	Submit history and physical and documentation of medical necessity, and procedure/imaging report
71250	Computed tomography, thorax, diagnostic; without contrast material	Prior Authorization Required	Medical Necessity	History and Physical, documentation of medical necessity
71260	Computed tomography, thorax, diagnostic; with contrast material(s)	Prior Authorization Required	Medical Necessity	History and Physical, documentation of medical necessity
71270	Computed tomography, thorax, diagnostic; without contrast material, followed by contrast material(s) and further sections	Prior Authorization Required	Medical Necessity	History and Physical, documentation of medical necessity
71271	Computed tomography, thorax, low dose for lung cancer screening, without contrast material(s)	Prior Authorization Required	Medical Necessity	History and Physical, documentation of medical necessity
71275	Computed tomographic angiography, chest (noncoronary), with contrast material(s), including noncontrast images, if performed, and image postprocessing	Prior Authorization Required	Medical Necessity	History and Physical, documentation of medical necessity
71550	Magnetic resonance (eg, proton) imaging, chest (eg, for evaluation of hilar and mediastinal lymphadenopathy); without contrast material(s)	Prior Authorization Required	Medical Necessity	History and Physical, documentation of medical necessity
71551	Magnetic resonance (eg, proton) imaging, chest (eg, for evaluation of hilar and mediastinal lymphadenopathy); with contrast material(s)	Prior Authorization Required	Medical Necessity	History and Physical, documentation of medical necessity

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Code List

Code	Description	Plan Review Requirement	Reviewed For	Records Request
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	Medical Necessity	History and Physical, documentation of medical necessity
71555	MRA chest; with or w/o contrast	Prior Authorization Required	Medical Necessity	History and Physical, documentation of medical necessity
72125	Computed tomography, cervical spine; without contrast material	Prior Authorization Required	Medical Necessity	History and Physical, documentation of medical necessity
72126	Computed tomography, cervical spine; with contrast material	Prior Authorization Required	Medical Necessity	History and Physical, documentation of medical necessity
72127	Computed tomography, cervical spine; without contrast material, followed by contrast material(s) and further sections	Prior Authorization Required	Medical Necessity	History and Physical, documentation of medical necessity
72128	Computed tomography, thoracic spine; without contrast material	Prior Authorization Required	Medical Necessity	History and Physical, documentation of medical necessity
72129	Computed tomography, thoracic spine; with contrast material	Prior Authorization Required	Medical Necessity	History and Physical, documentation of medical necessity
72130	Computed tomography, thoracic spine; without contrast material, followed by contrast material(s) and further sections	Prior Authorization Required	Medical Necessity	History and Physical, documentation of medical necessity
72131	Computed tomography, lumbar spine; without contrast material	Prior Authorization Required	Medical Necessity	History and Physical, documentation of medical necessity
72132	Computed tomography, lumbar spine; with contrast material	Prior Authorization Required	Medical Necessity	History and Physical, documentation of medical necessity
72133	Computed tomography, lumbar spine; without contrast material, followed by contrast material(s) and further sections	Prior Authorization Required	Medical Necessity	History and Physical, documentation of medical necessity
72141	Magnetic resonance (eg, proton) imaging, spinal canal and contents, cervical; without contrast material	Prior Authorization Required	Medical Necessity	History and Physical, documentation of medical necessity
72142	Magnetic resonance (eg, proton) imaging, spinal canal and contents, cervical; with contrast material(s)	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
72146	Magnetic resonance (eg, proton) imaging, spinal canal and contents, thoracic; without contrast material	Prior Authorization Required	Medical Necessity	History and Physical, documentation of medical necessity
72147	Magnetic resonance (eg, proton) imaging, spinal canal and contents, thoracic; with contrast material(s)	Prior Authorization Required	Medical Necessity	History and Physical, documentation of medical necessity
72148	Magnetic resonance (eg, proton) imaging, spinal canal and contents, lumbar; without contrast material	Prior Authorization Required	Medical Necessity	History and Physical, documentation of medical necessity
72149	Magnetic resonance (eg, proton) imaging, spinal canal and contents, lumbar; with contrast material(s)	Prior Authorization Required	Medical Necessity	History and Physical, documentation of medical necessity
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	Medical Necessity	History and Physical, documentation of medical necessity
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	Medical Necessity	History and Physical, documentation of medical necessity
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	Medical Necessity	History and Physical, documentation of medical necessity
72159	Magnetic resonance angiography, spinal canal and contents, with or without contrast material(s)	Prior Authorization Required	Medical Necessity	History and Physical, documentation of medical necessity
72191	Computed tomographic angiography, pelvis, with contrast material(s), including noncontrast images, if performed, and image postprocessing	Prior Authorization Required	Medical Necessity	History and Physical, documentation of medical necessity
72192	Computed tomography, pelvis; without contrast material	Prior Authorization Required	Medical Necessity	History and Physical, documentation of medical necessity

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Code List

Code	Description	Plan Review Requirement	Reviewed For	Records Request
72193	Computed tomography, pelvis; with contrast material(s)	Prior Authorization Required	Medical Necessity	History and Physical, documentation of medical necessity
72194	Computed tomography, pelvis; without contrast material, followed by contrast material(s) and further sections	Prior Authorization Required	Medical Necessity	History and Physical, documentation of medical necessity
72195	Magnetic resonance (eg, proton) imaging, pelvis; without contrast material(s)	Prior Authorization Required	Medical Necessity	History and Physical, documentation of medical necessity
72196	Magnetic resonance (eg, proton) imaging, pelvis; with contrast material(s)	Prior Authorization Required	Medical Necessity	History and Physical, documentation of medical necessity
72197	Magnetic resonance (eg, proton) imaging, pelvis; without contrast material(s), followed by contrast material(s) and further sequences	Prior Authorization Required	Medical Necessity	History and Physical, documentation of medical necessity
72198	Magnetic resonance angiography, pelvis, with or without contrast material(s)	Prior Authorization Required	Medical Necessity	History and Physical, documentation of medical necessity
73200	Computed tomography, upper extremity; without contrast material	Prior Authorization Required	Medical Necessity	History and Physical, documentation of medical necessity
73201	Computed tomography, upper extremity; with contrast material(s)	Prior Authorization Required	Medical Necessity	History and Physical, documentation of medical necessity
73202	Computed tomography, upper extremity; without contrast material, followed by contrast material(s) and further sections	Prior Authorization Required	Medical Necessity	History and Physical, documentation of medical necessity
73206	Computed tomographic angiography, upper extremity, with contrast material(s), including noncontrast images, if performed, and image postprocessing	Prior Authorization Required	Medical Necessity	History and Physical, documentation of medical necessity
73218	Magnetic resonance (eg, proton) imaging, upper extremity, other than joint; without contrast material(s)	Prior Authorization Required	Medical Necessity	History and Physical, documentation of medical necessity
73219	Magnetic resonance (eg, proton) imaging, upper extremity, other than joint; with contrast material(s)	Prior Authorization Required	Medical Necessity	History and Physical, documentation of medical necessity

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Code List

Code	Description	Plan Review Requirement	Reviewed For	Records Request
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	Medical Necessity	History and Physical, documentation of medical necessity
73221	Magnetic resonance (eg, proton) imaging, any joint of upper extremity; without contrast material(s)	Prior Authorization Required	Medical Necessity	History and Physical, documentation of medical necessity
73222	Magnetic resonance (eg, proton) imaging, any joint of upper extremity; with contrast material(s)	Prior Authorization Required	Medical Necessity	History and Physical, documentation of medical necessity
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	Medical Necessity	History and Physical, documentation of medical necessity
73225	Magnetic resonance angiography, upper extremity, with or without contrast material(s)	Prior Authorization Required	Medical Necessity	History and Physical, documentation of medical necessity
73700	Computed tomography, lower extremity; without contrast material	Prior Authorization Required	Medical Necessity	History and Physical, documentation of medical necessity
73701	Computed tomography, lower extremity; with contrast material(s)	Prior Authorization Required	Medical Necessity	History and Physical, documentation of medical necessity
73702	Computed tomography, lower extremity; without contrast material, followed by contrast material(s) and further sections	Prior Authorization Required	Medical Necessity	History and Physical, documentation of medical necessity
73706	Computed tomographic angiography, lower extremity, with contrast material(s), including noncontrast images, if performed, and image postprocessing	Prior Authorization Required	Medical Necessity	History and Physical, documentation of medical necessity
73718	Magnetic resonance (eg, proton) imaging, lower extremity other than joint; without contrast material(s)	Prior Authorization Required	Medical Necessity	Submit history and physical and documentation of medical necessity, and procedure/imaging report
73719	Magnetic resonance (eg, proton) imaging, lower extremity other than joint; with contrast material(s)	Prior Authorization Required	Medical Necessity	History and Physical, documentation of medical necessity

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Code List

Code	Description	Plan Review Requirement	Reviewed For	Records Request
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	Medical Necessity	History and Physical, documentation of medical necessity
73721	Magnetic resonance (eg, proton) imaging, any joint of lower extremity; without contrast material	Prior Authorization Required	Medical Necessity	History and Physical, documentation of medical necessity
73722	Magnetic resonance (eg, proton) imaging, any joint of lower extremity; with contrast material(s)	Prior Authorization Required	Medical Necessity	History and Physical, documentation of medical necessity
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	Medical Necessity	History and Physical, documentation of medical necessity
73725	Magnetic resonance angiography, lower extremity, with or without contrast material(s)	Prior Authorization Required	Medical Necessity	History and Physical, documentation of medical necessity
74150	Computed tomography, abdomen; without contrast material	Prior Authorization Required	Medical Necessity	History and Physical, documentation of medical necessity
74160	Computed tomography, abdomen; with contrast material(s)	Prior Authorization Required	Medical Necessity	History and Physical, documentation of medical necessity
74170	Computed tomography, abdomen; without contrast material, followed by contrast material(s) and further sections	Prior Authorization Required	Medical Necessity	History and Physical, documentation of medical necessity
74174	Computed tomographic angiography, abdomen and pelvis, with contrast material(s), including noncontrast images, if performed, and image postprocessing	Prior Authorization Required	Medical Necessity	History and Physical, documentation of medical necessity
74175	Computed tomographic angiography, abdomen, with contrast material(s), including noncontrast images, if performed, and image postprocessing	Prior Authorization Required	Medical Necessity	History and Physical, documentation of medical necessity
74176	Computed tomography, abdomen and pelvis; without contrast material	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
74177	Computed tomography, abdomen and pelvis; with contrast material(s)	Prior Authorization Required	Medical Necessity	History and Physical, documentation of medical necessity
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	Medical Necessity	History and Physical, documentation of medical necessity
74181	Magnetic resonance (eg, proton) imaging, abdomen; without contrast material(s)	Prior Authorization Required	Medical Necessity	History and Physical, documentation of medical necessity
74182	Magnetic resonance (eg, proton) imaging, abdomen; with contrast material(s)	Prior Authorization Required	Medical Necessity	History and Physical, documentation of medical necessity
74183	Magnetic resonance (eg, proton) imaging, abdomen; without contrast material(s), followed by with contrast material(s) and further sequences	Prior Authorization Required	Medical Necessity	History and Physical, documentation of medical necessity
74185	Magnetic resonance angiography, abdomen, with or without contrast material(s)	Prior Authorization Required	Medical Necessity	History and Physical, documentation of medical necessity
74261	Computed tomographic (CT) colonography, diagnostic, including image postprocessing; without contrast material	Prior Authorization Required	Medical Necessity	History and Physical, documentation of medical necessity
74262	Computed tomographic (CT) colonography, diagnostic, including image postprocessing; with contrast material(s) including non-contrast images, if performed	Prior Authorization Required	Medical Necessity	History and Physical, documentation of medical necessity
74712	Magnetic resonance (eg, proton) imaging, fetal, including placental and maternal pelvic imaging when performed; single or first gestation	Prior Authorization Required	Medical Necessity	History and Physical, documentation of medical necessity

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Code List

Code	Description	Plan Review Requirement	Reviewed For	Records Request
74713	Magnetic resonance (eg, proton) imaging, fetal, including placental and maternal pelvic imaging when performed; each additional gestation (List separately in addition to code for primary procedure)	Prior Authorization Required	Medical Necessity	Submit history and physical and documentation of medical necessity, and procedure/imaging report
75557	Cardiac magnetic resonance imaging for morphology and function without contrast material;	Prior Authorization Required	Medical Necessity	Submit history and physical and documentation of medical necessity, and procedure/imaging report
75559	Cardiac magnetic resonance imaging for morphology and function without contrast material; with stress imaging	Prior Authorization Required	Medical Necessity	Submit history and physical and documentation of medical necessity, and procedure/imaging report
75561	Cardiac magnetic resonance imaging for morphology and function without contrast material(s), followed by contrast material(s) and further sequences;	Prior Authorization Required	Medical Necessity	Submit history and physical and documentation of medical necessity, and procedure/imaging 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	Medical Necessity	Submit history and physical and documentation of medical necessity, and procedure/imaging report
75565	Cardiac magnetic resonance imaging for velocity flow mapping (List separately in addition to code for primary procedure)	Prior Authorization Required	Medical Necessity	Submit history and physical and documentation of medical necessity, and procedure/imaging report
75571	Computed tomography, heart, without contrast material, with quantitative evaluation of coronary calcium	Prior Authorization Required	Medical Necessity	Submit history and physical and documentation of medical necessity, and procedure/imaging 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	Medical Necessity	Submit history and physical and documentation of medical necessity, and procedure/imaging report

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Code List

Code	Description	Plan Review Requirement	Reviewed For	Records Request
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	Medical Necessity	Submit history and physical and documentation of medical necessity, and procedure/imaging report
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	Medical Necessity	Submit history and physical and documentation of medical necessity, and procedure/imaging 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	Medical Necessity	Submit history and physical and documentation of medical necessity, and procedure/imaging 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	Medical Necessity	History and Physical, documentation of medical necessity
76120	Cineradiography/videoradiography, except where specifically included	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and Physical, documentation of medical necessity
76125	Cineradiography/videoradiography to complement routine examination (List separately in addition to code for primary procedure)	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, documentation of medical necessity and plan of care

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Code List

Code	Description	Plan Review Requirement	Reviewed For	Records Request
76376	3D rendering with interpretation and reporting of computed tomography, magnetic resonance imaging, ultrasound, or other tomographic modality with image postprocessing under concurrent supervision; not requiring image postprocessing on an independent workstation	Prior Authorization Required	Medical Necessity	Submit history and physical and documentation of medical necessity, and procedure/imaging report
76377	3D rendering with interpretation and reporting of computed tomography, magnetic resonance imaging, ultrasound, or other tomographic modality with image postprocessing under concurrent supervision; requiring image postprocessing on an independent workstation	Prior Authorization Required	Medical Necessity	Submit history and physical and documentation of medical necessity, and procedure/imaging report
76380	Computed tomography, limited or localized follow-up study	Prior Authorization Required	Medical Necessity	Submit history and physical and documentation of medical necessity, and procedure/imaging report
76390	Magnetic resonance spectroscopy	Prior Authorization Required	Medical Necessity	Submit history and physical and documentation of medical necessity, and procedure/imaging report
76391	Magnetic resonance (eg, vibration) elastography	Prior Authorization Required	Medical Necessity	History and Physical, documentation of medical necessity
76496	Unlisted fluoroscopic procedure (eg, diagnostic, interventional)	Advance Benefit Determination (ABD) recommended	Medical Necessity	Office notes from ordering provider related to billed services and radiology report, as well as documentation to describe services
76497	Unlisted computed tomography procedure (eg, diagnostic interventional)	Prior Authorization Required	Medical Necessity	Submit documentation to describe services; include office notes from ordering provider related to billed services and radiology report
76498	Unlisted magnetic resonance procedure (eg, diagnostic, interventional)	Prior Authorization Required	Medical Necessity	Submit documentation to describe services; include office notes from ordering provider related to billed services and radiology report

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
76499	Unlisted diagnostic radiographic procedure	Advance Benefit Determination (ABD) recommended	Medical Necessity	Office notes from ordering provider related to billed services and radiology report, as well as documentation to describe services
76948	Ultrasonic guidance for aspiration of ova, imaging supervision and interpretation	Prior Authorization Required	Potential Contract Exclusion	History and physical, and documentation of infertility, including treatment plan
76977	Ultrasound bone density measurement and interpretation, peripheral site(s), any method	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history and physical, documentation of medical necessity.
76999	Unlisted ultrasound procedure (eg, diagnostic, interventional)	Advance Benefit Determination (ABD) recommended	Medical Necessity	Office notes from ordering provider related to billed services and radiology report, as well as documentation to describe services
77011	Computed tomography guidance for stereotactic localization	Prior Authorization Required	Medical Necessity	Submit history and physical and documentation of medical necessity, and procedure/imaging report
77012	Computed tomography guidance for needle placement (eg, biopsy, aspiration, injection, localization device), radiological supervision and interpretation	Prior Authorization Required	Medical Necessity	Submit history and physical and documentation of medical necessity, and procedure/imaging report
77013	Computed tomography guidance for, and monitoring of, parenchymal tissue ablation	Prior Authorization Required	Medical Necessity	History and Physical, documentation of medical necessity
77014	Computed tomography guidance for placement of radiation therapy fields	Prior Authorization Required	Medical Necessity	Submit history and physical and documentation of medical necessity, and procedure/imaging report
77021	Magnetic resonance imaging guidance for needle placement (eg, for biopsy, needle aspiration, injection, or placement of localization device) radiological supervision and interpretation	Prior Authorization Required	Medical Necessity	Submit history and physical and documentation of medical necessity, and procedure/imaging report
77022	Magnetic resonance imaging guidance for, and monitoring of, parenchymal tissue ablation	Prior Authorization Required	Medical Necessity	Submit history and physical and documentation of medical necessity, and procedure/imaging report

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
77046	Magnetic resonance imaging, breast, without contrast material; unilateral	Prior Authorization Required	Medical Necessity	History and Physical, documentation of medical necessity
77047	Magnetic resonance imaging, breast, without contrast material; bilateral	Prior Authorization Required	Medical Necessity	History and Physical, documentation of medical necessity
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	Medical Necessity	History and Physical, documentation of medical necessity
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	Medical Necessity	History and Physical, documentation of medical necessity
77078	Computed tomography, bone mineral density study, 1 or more sites; axial skeleton (eg, hips, pelvis, spine)	Prior Authorization Required	Medical Necessity	Submit history and physical and documentation of medical necessity, and procedure/imaging report
77084	Magnetic resonance (eg, proton) imaging, bone marrow blood supply	Prior Authorization Required	Medical Necessity	History and Physical, documentation of medical necessity
77085	Dual-energy X-ray absorptiometry (DXA), bone density study, 1 or more sites; axial skeleton (eg, hips, pelvis, spine), including vertebral fracture assessment	Advance Benefit Determination (ABD) recommended	Investigative	History and Physical, documentation of medical necessity NOTE: Claims for this drug are processed through the Local Plan, not pharmacy.
77086	Vertebral fracture assessment via dual-energy X-ray absorptiometry (DXA)	Advance Benefit Determination (ABD) recommended	Investigative	Submit history and physical, documentation of medical necessity and procedure report.
77299	Unlisted procedure, therapeutic radiology clinical treatment planning	Advance Benefit Determination (ABD) recommended	Medical Necessity	Office notes from ordering provider related to billed services and radiology report, as well as documentation to describe services

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Code List

Code	Description	Plan Review Requirement	Reviewed For	Records Request
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	Medical Necessity	History and Physical, documentation of medical necessity
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	Medical Necessity	History and physical, including functional capacity, if metastatic and number of lesions
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	Medical Necessity	History and physical, including functional capacity, if metastatic and number of lesions
77399	Unlisted procedure, medical radiation physics, dosimetry and treatment devices, and special services	Advance Benefit Determination (ABD) recommended	Medical Necessity	Office notes from ordering provider related to billed services and radiology report, as well as documentation to describe services
77432	Stereotactic radiation treatment management of cranial lesion(s) (complete course of treatment consisting of 1 session)	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, including functional capacity, if metastatic and number of lesions. medical necessity review will be performed upon claims submission with supporting documentation
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	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, including functional capacity, if metastatic and number of lesions. medical necessity review will be performed upon claims submission with supporting documentation
77499	Unlisted procedure, therapeutic radiology treatment management	Advance Benefit Determination (ABD) recommended	Medical Necessity	Office notes from ordering provider related to billed services and radiology report, as well as documentation to describe services

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
77520	Proton treatment delivery; simple, without compensation	Prior Authorization Required	Medical Necessity	History and physical, and documentation of medical necessity, and treatment plan.
77522	Proton treatment delivery; simple, with compensation	Prior Authorization Required	Medical Necessity	History and physical, and documentation of medical necessity, and treatment plan.
77523	Proton treatment delivery; intermediate	Prior Authorization Required	Medical Necessity	History and physical, and documentation of medical necessity, and treatment plan.
77525	Proton treatment delivery; complex	Prior Authorization Required	Medical Necessity	History and physical, and documentation of medical necessity, and treatment plan.
77620	Hyperthermia generated by intracavitary probe(s)	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history and physical, documentation of medical necessity and procedure report.
77799	Unlisted procedure, clinical brachytherapy	Advance Benefit Determination (ABD) recommended	Medical Necessity	Office notes from ordering provider related to billed services and radiology report, as well as documentation to describe services
78071	Parathyroid planar imaging (including subtraction, when performed); with tomographic (SPECT)	Prior Authorization Required	Medical Necessity	Submit history and physical and documentation of medical necessity, and procedure/imaging report
78072	Parathyroid planar imaging (including subtraction, when performed); with tomographic (SPECT), and concurrently acquired computed tomography (CT) for anatomical localization	Prior Authorization Required	Medical Necessity	History and Physical, documentation of medical necessity
78099	Unlisted endocrine procedure, diagnostic nuclear medicine	Advance Benefit Determination (ABD) recommended	Medical Necessity	Office notes from ordering provider related to billed services and radiology report, as well as documentation to describe services
78199	Unlisted hematopoietic, reticuloendothelial and lymphatic procedure, diagnostic nuclear medicine	Advance Benefit Determination (ABD) recommended	Medical Necessity	Office notes from ordering provider related to billed services and radiology report, as well as documentation to describe services

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78299	Unlisted gastrointestinal procedure, diagnostic nuclear medicine	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical with operative/procedure report, as well as documentation to describe services
78350	Bone density (bone mineral content) study, 1 or more sites; single photon absorptiometry	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history and physical, documentation of medical necessity.
78351	Bone density (bone mineral content) study, 1 or more sites; dual photon absorptiometry, 1 or more sites	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history and physical, documentation of medical necessity.
78399	Unlisted musculoskeletal procedure, diagnostic nuclear medicine	Advance Benefit Determination (ABD) recommended	Medical Necessity	Office notes from ordering provider related to billed services and radiology report, as well as documentation to describe services
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	Medical Necessity	Submit history and physical and documentation of medical necessity, and procedure/imaging 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	Medical Necessity	Submit history and physical and documentation of medical necessity, and procedure/imaging 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	Medical Necessity	Submit history and physical and documentation of medical necessity, and procedure/imaging report

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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	Medical Necessity	Submit history and physical and documentation of medical necessity, and procedure/imaging report
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	Medical Necessity	Submit history and physical and documentation of medical necessity, and procedure/imaging 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	Medical Necessity	Submit history and physical and documentation of medical necessity, and procedure/imaging 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	Medical Necessity	Submit history and physical and documentation of medical necessity, and procedure/imaging 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	Medical Necessity	Submit history and physical and documentation of medical necessity, and procedure/imaging report

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78469	Myocardial imaging, infarct avid, planar; tomographic SPECT with or without quantification	Prior Authorization Required	Medical Necessity	Submit history and physical and documentation of medical necessity, and procedure/imaging 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	Medical Necessity	Submit history and physical and documentation of medical necessity, and procedure/imaging 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	Medical Necessity	Submit history and physical and documentation of medical necessity, and procedure/imaging 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	Medical Necessity	Submit history and physical and documentation of medical necessity, and procedure/imaging report
78499	Unlisted cardiovascular procedure, diagnostic nuclear medicine	Advance Benefit Determination (ABD) recommended	Medical Necessity	Office notes from ordering provider related to billed services and radiology report, as well as documentation to describe services
78599	Unlisted respiratory procedure, diagnostic nuclear medicine	Advance Benefit Determination (ABD) recommended	Medical Necessity	Office notes from ordering provider related to billed services and radiology report, as well as documentation to describe services
78699	Unlisted nervous system procedure, diagnostic nuclear medicine	Advance Benefit Determination (ABD) recommended	Medical Necessity	Office notes from ordering provider related to billed services and radiology report, as well as documentation to describe services
78799	Unlisted genitourinary procedure, diagnostic nuclear medicine	Advance Benefit Determination (ABD) recommended	Medical Necessity	Office notes from ordering provider related to billed services and radiology report, as well as documentation to describe services

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78803	Radiopharmaceutical localization of tumor, inflammatory process or distribution of radiopharmaceutical agent(s) (includes vascular flow and blood pool imaging, when performed); tomographic (SPECT), single area (eg, head, neck, chest, pelvis) or acquisition, single day imaging	Prior Authorization Required	Medical Necessity	Submit history and physical and documentation of medical necessity, and procedure/imaging report
78830	Radiopharmaceutical localization of tumor, inflammatory process or distribution of radiopharmaceutical agent(s) (includes vascular flow and blood pool imaging, when performed); tomographic (SPECT) with concurrently acquired computed tomography (CT) transmission scan for anatomical review, localization and determination/detection of pathology, single area (eg, head, neck, chest, pelvis) or acquisition, single day imaging	Prior Authorization Required	Medical Necessity	Submit history and physical and documentation of medical necessity, and procedure/imaging report
78831	Radiopharmaceutical localization of tumor, inflammatory process or distribution of radiopharmaceutical agent(s) (includes vascular flow and blood pool imaging, when performed); tomographic (SPECT), minimum 2 areas (eg, pelvis and knees, chest and abdomen) or separate acquisitions (eg, lung ventilation and perfusion), single day imaging, or single area or acquisition over 2 or more days	Prior Authorization Required	Medical Necessity	Submit history and physical and documentation of medical necessity, and procedure/imaging report

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78832	Radiopharmaceutical localization of tumor, inflammatory process or distribution of radiopharmaceutical agent(s) (includes vascular flow and blood pool imaging, when performed); tomographic (SPECT) with concurrently acquired computed tomography (CT) transmission scan for anatomical review, localization and determination/detection of pathology, minimum 2 areas (eg, pelvis and knees, chest and abdomen) or separate acquisitions (eg, lung ventilation and perfusion), single day imaging, or single area or acquisition over 2 or more days	Prior Authorization Required	Medical Necessity	Submit history and physical and documentation of medical necessity, and procedure/imaging report
78835	Radiopharmaceutical quantification measurement(s) single area (List separately in addition to code for primary procedure)	Prior Authorization Required	Medical Necessity	Submit history and physical and documentation of medical necessity, and procedure/imaging report
78999	Unlisted miscellaneous procedure, diagnostic nuclear medicine	Advance Benefit Determination (ABD) recommended	Medical Necessity	Office notes from ordering provider related to billed services and radiology report, as well as documentation to describe services
79403	Radiopharmaceutical therapy, radiolabeled monoclonal antibody by intravenous infusion	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history and physical, documentation of medical necessity and procedure report.
79445	Radiopharmaceutical therapy, by intra-arterial particulate administration	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history and physical, documentation of medical necessity and procedure report.
79999	Radiopharmaceutical therapy, unlisted procedure	Advance Benefit Determination (ABD) recommended	Medical Necessity	Office notes from ordering provider related to billed services and radiology report, as well as documentation to describe services

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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	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and Physical, documentation of medical necessity
81120	IDH1 (isocitrate dehydrogenase 1 [NADP+], soluble) (eg, glioma), common variants (eg, R132H, R132C)	Prior Authorization Required	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
81121	IDH2 (isocitrate dehydrogenase 2 [NADP+], mitochondrial) (eg, glioma), common variants (eg, R140W, R172M)	Prior Authorization Required	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
81161	DMD (dystrophin) (eg, Duchenne/Becker muscular dystrophy) deletion analysis, and duplication analysis, if performed	Prior Authorization Required	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
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	Medical Necessity Review Required	History and physical, and clinical documentation supporting the reasoning for testing (including family history)
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	Medical Necessity Review Required	History and physical, and clinical documentation supporting the reasoning for testing (including family history)
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	Medical Necessity Review Required	History and physical, and clinical documentation supporting the reasoning for testing (including family history)

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81165	BRCA1 (BRCA1, DNA repair associated) (eg, hereditary breast and ovarian cancer) gene analysis; full sequence analysis	Prior Authorization Required	Medical Necessity Review Required	History and physical, and clinical documentation supporting the reasoning for testing (including family history)
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	Medical Necessity Review Required	History and physical, and clinical documentation supporting the reasoning for testing (including family history)
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	Medical Necessity Review Required	History and physical, and clinical documentation supporting the reasoning for testing (including family history)
81168	CCND1/IGH (t(11;14)) (eg, mantle cell lymphoma) translocation analysis, major breakpoint, qualitative and quantitative, if performed	Prior Authorization Required	Medical Necessity	History and Physical, documentation of medical necessity
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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
81173	AR (androgen receptor) (eg, spinal and bulbar muscular atrophy, Kennedy disease, X chromosome inactivation) gene analysis; full gene sequence	Prior Authorization Required	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing

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81174	AR (androgen receptor) (eg, spinal and bulbar muscular atrophy, Kennedy disease, X chromosome inactivation) gene analysis; known familial variant	Prior Authorization Required	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
81177	ATN1 (atrophin 1) (eg, dentatorubral-pallidoluysian atrophy) gene analysis, evaluation to detect abnormal (eg, expanded) alleles	Prior Authorization Required	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
81178	ATXN1 (ataxin 1) (eg, spinocerebellar ataxia) gene analysis, evaluation to detect abnormal (eg, expanded) alleles	Prior Authorization Required	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
81179	ATXN2 (ataxin 2) (eg, spinocerebellar ataxia) gene analysis, evaluation to detect abnormal (eg, expanded) alleles	Prior Authorization Required	Medical Necessity	History and Physical, documentation of medical necessity
81180	ATXN3 (ataxin 3) (eg, spinocerebellar ataxia, Machado-Joseph disease) gene analysis, evaluation to detect abnormal (eg, expanded) alleles	Prior Authorization Required	Medical Necessity	History and Physical, documentation of medical necessity
81181	ATXN7 (ataxin 7) (eg, spinocerebellar ataxia) gene analysis, evaluation to detect abnormal (eg, expanded) alleles	Prior Authorization Required	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing

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81182	ATXN8OS (ATXN8 opposite strand [non-protein coding]) (eg, spinocerebellar ataxia) gene analysis, evaluation to detect abnormal (eg, expanded) alleles	Prior Authorization Required	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
81183	ATXN10 (ataxin 10) (eg, spinocerebellar ataxia) gene analysis, evaluation to detect abnormal (eg, expanded) alleles	Prior Authorization Required	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
81184	CACNA1A (calcium voltage-gated channel subunit alpha1 A) (eg, spinocerebellar ataxia) gene analysis; evaluation to detect abnormal (eg, expanded) alleles	Prior Authorization Required	Medical Necessity	History and Physical, documentation of medical necessity
81185	CACNA1A (calcium voltage-gated channel subunit alpha1 A) (eg, spinocerebellar ataxia) gene analysis; full gene sequence	Prior Authorization Required	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
81186	CACNA1A (calcium voltage-gated channel subunit alpha1 A) (eg, spinocerebellar ataxia) gene analysis; known familial variant	Prior Authorization Required	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
81188	CSTB (cystatin B) (eg, Unverricht-Lundborg disease) gene analysis; evaluation to detect abnormal (eg, expanded) alleles	Prior Authorization Required	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
81189	CSTB (cystatin B) (eg, Unverricht-Lundborg disease) gene analysis; full gene sequence	Prior Authorization Required	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
81190	CSTB (cystatin B) (eg, Unverricht-Lundborg disease) gene analysis; known familial variant(s)	Prior Authorization Required	Medical Necessity	History and Physical, documentation of medical necessity

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Code List

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81191	NTRK1 (neurotrophic receptor tyrosine kinase 1) (eg, solid tumors) translocation analysis	Prior Authorization Required	Medical Necessity	History and Physical, clinical notes related to a condition being treated, documentation of previous therapies tried and failed.
81192	NTRK2 (neurotrophic receptor tyrosine kinase 2) (eg, solid tumors) translocation analysis	Prior Authorization Required	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
81193	NTRK3 (neurotrophic receptor tyrosine kinase 3) (eg, solid tumors) translocation analysis	Prior Authorization Required	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
81194	NTRK (neurotrophic-tropomyosin receptor tyrosine kinase 1, 2, and 3) (eg, solid tumors) translocation analysis	Prior Authorization Required	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
81200	ASPA (aspartoacylase) (eg, Canavan disease) gene analysis, common variants (eg, E285A, Y231X)	Prior Authorization Required	Medical Necessity	History and Physical, documentation of medical necessity
81201	APC (adenomatous polyposis coli) (eg, familial adenomatosis polyposis [FAP], attenuated FAP) gene analysis; full gene sequence	Prior Authorization Required	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
81202	APC (adenomatous polyposis coli) (eg, familial adenomatosis polyposis [FAP], attenuated FAP) gene analysis; known familial variants	Prior Authorization Required	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
81203	APC (adenomatous polyposis coli) (eg, familial adenomatosis polyposis [FAP], attenuated FAP) gene analysis; duplication/deletion variants	Prior Authorization Required	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing

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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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
81206	BCR/ABL1 (t(9;22)) (eg, chronic myelogenous leukemia) translocation analysis; major breakpoint, qualitative or quantitative	Prior Authorization Required	Medical Necessity	History and Physical, documentation of medical necessity
81207	BCR/ABL1 (t(9;22)) (eg, chronic myelogenous leukemia) translocation analysis; minor breakpoint, qualitative or quantitative	Prior Authorization Required	Medical Necessity	History and physical, and chart notes from ordering provider with reason for testing
81208	BCR/ABL1 (t(9;22)) (eg, chronic myelogenous leukemia) translocation analysis; other breakpoint, qualitative or quantitative	Prior Authorization Required	Medical Necessity	History and physical, and chart notes from ordering provider with reason for testing
81209	BLM (Bloom syndrome, RecQ helicase-like) (eg, Bloom syndrome) gene analysis, 2281del6ins7 variant	Prior Authorization Required	Medical Necessity	History and Physical, documentation of medical necessity
81210	BRAF (v-raf murine sarcoma viral oncogene homolog B1) (eg, colon cancer), gene analysis, V600E variant	Prior Authorization Required	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
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	Medical Necessity	History and physical, and clinical documentation supporting the reasoning for testing (including family history)
81215	BRCA1 (BRCA1, DNA repair associated) (eg, hereditary breast and ovarian cancer) gene analysis; known familial variant	Prior Authorization Required	Medical Necessity	History and physical, and clinical documentation supporting the reasoning for testing (including family history)
81216	BRCA2 (BRCA2, DNA repair associated) (eg, hereditary breast and ovarian cancer) gene analysis; full sequence analysis	Prior Authorization Required	Medical Necessity	History and physical, and clinical documentation supporting the reasoning for testing (including family history)

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
81217	BRCA2 (BRCA2, DNA repair associated) (eg, hereditary breast and ovarian cancer) gene analysis; known familial variant	Prior Authorization Required	Medical Necessity	History and physical, and clinical documentation supporting the reasoning for testing (including family history)
81218	CEBPA (CCAAT/enhancer binding protein [C/EBP], alpha) (eg, acute myeloid leukemia), gene analysis, full gene sequence	Prior Authorization Required	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
81219	CALR (calreticulin) (eg, myeloproliferative disorders), gene analysis, common variants in exon 9	Prior Authorization Required	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
81220	CFTR (cystic fibrosis transmembrane conductance regulator) (eg, cystic fibrosis) gene analysis; common variants (eg, ACMG/ACOG guidelines)	Prior Authorization Required	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
81221	CFTR (cystic fibrosis transmembrane conductance regulator) (eg, cystic fibrosis) gene analysis; known familial variants	Prior Authorization Required	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
81222	CFTR (cystic fibrosis transmembrane conductance regulator) (eg, cystic fibrosis) gene analysis; duplication/deletion variants	Prior Authorization Required	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
81223	CFTR (cystic fibrosis transmembrane conductance regulator) (eg, cystic fibrosis) gene analysis; full gene sequence	Prior Authorization Required	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
81224	CFTR (cystic fibrosis transmembrane conductance regulator) (eg, cystic fibrosis) gene analysis; intron 8 poly-T analysis (eg, male infertility)	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, treatment plan
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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing

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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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
81228	Cytogenomic constitutional (genome-wide) microarray analysis; interrogation of genomic regions for copy number variants	Prior Authorization Required	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
81230	CYP3A4 (cytochrome P450 family 3 subfamily A member 4) (eg, drug metabolism), gene analysis, common variant(s) (eg, *2, *22)	Prior Authorization Required	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
81231	CYP3A5 (cytochrome P450 family 3 subfamily A member 5) (eg, drug metabolism), gene analysis, common variants (eg, *2, *3, *4, *5, *6, *7)	Prior Authorization Required	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
81232	DPYD (dihydropyrimidine dehydrogenase) (eg, 5-fluorouracil/5-FU and capecitabine drug metabolism), gene analysis, common variant(s) (eg, *2A, *4, *5, *6)	Prior Authorization Required	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
81233	BTK (Bruton's tyrosine kinase) (eg, chronic lymphocytic leukemia) gene analysis, common variants (eg, C481S, C481R, C481F)	Prior Authorization Required	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing

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81234	DMPK (DM1 protein kinase) (eg, myotonic dystrophy type 1) gene analysis; evaluation to detect abnormal (expanded) alleles	Prior Authorization Required	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
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	Medical Necessity	History and Physical, documentation of medical necessity
81236	EZH2 (enhancer of zeste 2 polycomb repressive complex 2 subunit) (eg, myelodysplastic syndrome, myeloproliferative neoplasms) gene analysis, full gene sequence	Prior Authorization Required	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
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	Medical Necessity	History and physical, documentation of medical necessity, treatment plan
81238	F9 (coagulation factor IX) (eg, hemophilia B), full gene sequence	Prior Authorization Required	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
81239	DMPK (DM1 protein kinase) (eg, myotonic dystrophy type 1) gene analysis; characterization of alleles (eg, expanded size)	Prior Authorization Required	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
81240	F2 (prothrombin, coagulation factor II) (eg, hereditary hypercoagulability) gene analysis, 20210G>A variant	Prior Authorization Required	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
81241	F5 (coagulation factor V) (eg, hereditary hypercoagulability) gene analysis, Leiden variant	Prior Authorization Required	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing

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81242	FANCC (Fanconi anemia, complementation group C) (eg, Fanconi anemia, type C) gene analysis, common variant (eg, IVS4+4A>T)	Prior Authorization Required	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
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	Medical Necessity	History and Physical, clinical notes related to a condition being treated, documentation of previous therapies tried and failed.
81246	FLT3 (fms-related tyrosine kinase 3) (eg, acute myeloid leukemia), gene analysis; tyrosine kinase domain (TKD) variants (eg, D835, I836)	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, documentation of medical necessity, and documentation of previous therapies/treatments tried
81247	G6PD (glucose-6-phosphate dehydrogenase) (eg, hemolytic anemia, jaundice), gene analysis; common variant(s) (eg, A, A-)	Prior Authorization Required	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
81248	G6PD (glucose-6-phosphate dehydrogenase) (eg, hemolytic anemia, jaundice), gene analysis; known familial variant(s)	Prior Authorization Required	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing

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81249	G6PD (glucose-6-phosphate dehydrogenase) (eg, hemolytic anemia, jaundice), gene analysis; full gene sequence	Prior Authorization Required	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
81251	GBA (glucosidase, beta, acid) (eg, Gaucher disease) gene analysis, common variants (eg, N370S, 84GG, L444P, IVS2+1G>A)	Prior Authorization Required	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
81252	GJB2 (gap junction protein, beta 2, 26kDa, connexin 26) (eg, nonsyndromic hearing loss) gene analysis; full gene sequence	Prior Authorization Required	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
81253	GJB2 (gap junction protein, beta 2, 26kDa, connexin 26) (eg, nonsyndromic hearing loss) gene analysis; known familial variants	Prior Authorization Required	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
81257	HBA1/HBA2 (alpha globin 1 and alpha globin 2) (e.g., alpha thalassemia, Hb Bart hydrops fetalis syndrome, HbH disease), gene analysis, for common deletions or variant	Prior Authorization Required	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing

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81258	HBA1/HBA2 (alpha globin 1 and alpha globin 2) (eg, alpha thalassemia, Hb Bart hydrops fetalis syndrome, HbH disease), gene analysis; known familial variant	Prior Authorization Required	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
81263	IGH@ (Immunoglobulin heavy chain locus) (eg, leukemia and lymphoma, B-cell), variable region somatic mutation analysis	Prior Authorization Required	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing

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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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
81270	JAK2 (Janus kinase 2) (eg, myeloproliferative disorder) gene analysis, p.Val617Phe (V617F) variant	Prior Authorization Required	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
81271	HTT (huntingtin) (eg, Huntington disease) gene analysis; evaluation to detect abnormal (eg, expanded) alleles	Prior Authorization Required	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
81273	KIT (v-kit Hardy-Zuckerman 4 feline sarcoma viral oncogene homolog) (eg, mastocytosis), gene analysis, D816 variant(s)	Prior Authorization Required	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
81274	HTT (huntingtin) (eg, Huntington disease) gene analysis; characterization of alleles (eg, expanded size)	Prior Authorization Required	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
81275	KRAS (Kirsten rat sarcoma viral oncogene homolog) (eg, carcinoma) gene analysis; variants in exon 2 (eg, codons 12 and 13)	Prior Authorization Required	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
81276	KRAS (Kirsten rat sarcoma viral oncogene homolog) (eg, carcinoma) gene analysis; additional variant(s) (eg, codon 61, codon 146)	Prior Authorization Required	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing

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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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
81279	JAK2 (Janus kinase 2) (eg, myeloproliferative disorder) targeted sequence analysis (eg, exons 12 and 13)	Prior Authorization Required	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
81283	IFNL3 (interferon, lambda 3) (eg, drug response), gene analysis, rs12979860 variant	Prior Authorization Required	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
81284	FXN (frataxin) (eg, Friedreich ataxia) gene analysis; evaluation to detect abnormal (expanded) alleles	Prior Authorization Required	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
81285	FXN (frataxin) (eg, Friedreich ataxia) gene analysis; characterization of alleles (eg, expanded size)	Prior Authorization Required	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
81286	FXN (frataxin) (eg, Friedreich ataxia) gene analysis; full gene sequence	Prior Authorization Required	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
81287	MGMT (o-6-methylguanine-dna methyltransferase) (eg, glioblastoma multiforme) promoter methylation analysis	Prior Authorization Required	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing

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81288	MLH1 (mutL homolog 1, colon cancer, nonpolyposis type 2) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; promoter methylation analysis	Prior Authorization Required	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
81289	FXN (frataxin) (eg, Friedreich ataxia) gene analysis; known familial variant(s)	Prior Authorization Required	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
81290	MCOLN1 (mucolipin 1) (eg, Mucolipidosis, type IV) gene analysis, common variants (eg, IVS3-2A>G, del6.4kb)	Prior Authorization Required	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
81291	MTHFR (5,10-methylenetetrahydrofolate reductase) (eg, hereditary hypercoagulability) gene analysis, common variants (eg, 677T, 1298C)	Prior Authorization Required	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing

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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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
81298	MSH6 (mutS homolog 6 [E. coli]) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; full sequence analysis	Prior Authorization Required	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
81299	MSH6 (mutS homolog 6 [E. coli]) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; known familial variants	Prior Authorization Required	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
81300	MSH6 (mutS homolog 6 [E. coli]) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; duplication/deletion variants	Prior Authorization Required	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
81301	Microsatellite instability analysis (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) of markers for mismatch repair deficiency (eg, BAT25, BAT26), includes comparison of neoplastic and normal tissue, if performed	Prior Authorization Required	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
81302	MECP2 (methyl CpG binding protein 2) (eg, Rett syndrome) gene analysis; full sequence analysis	Prior Authorization Required	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
81303	MECP2 (methyl CpG binding protein 2) (eg, Rett syndrome) gene analysis; known familial variant	Prior Authorization Required	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing

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Code List

Code	Description	Plan Review Requirement	Reviewed For	Records Request
81304	MECP2 (methyl CpG binding protein 2) (eg, Rett syndrome) gene analysis; duplication/deletion variants	Prior Authorization Required	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
81305	MYD88 (myeloid differentiation primary response 88) (eg, Waldenstrom's macroglobulinemia, lymphoplasmacytic leukemia) gene analysis, p.Leu265Pro (L265P) variant	Prior Authorization Required	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
81306	NUDT15 (nudix hydrolase 15) (eg, drug metabolism) gene analysis, common variant(s) (eg, *2, *3, *4, *5, *6)	Prior Authorization Required	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
81307	PALB2 (partner and localizer of BRCA2) (EG, breast and pancreatic cancer) gene analysis; full gene sequence	Prior Authorization Required	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
81308	PALB2 (partner and localizer of BRCA2) (EG, breast and pancreatic cancer) gene analysis; known familial variant	Prior Authorization Required	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
81310	NPM1 (nucleophosmin) (eg, acute myeloid leukemia) gene analysis, exon 12 variants	Prior Authorization Required	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing

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81312	PABPN1 (poly[A] binding protein nuclear 1) (eg, oculopharyngeal muscular dystrophy) gene analysis, evaluation to detect abnormal (eg, expanded) alleles	Prior Authorization Required	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
81313	PCA3/KLK3 (prostate cancer antigen 3 [non-protein coding]/kallikrein-related peptidase 3 [prostate specific antigen]) ratio (eg, prostate cancer)	Prior Authorization Required	Investigative	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
81317	PMS2 (postmeiotic segregation increased 2 [S. cerevisiae]) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; full sequence analysis	Prior Authorization Required	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
81318	PMS2 (postmeiotic segregation increased 2 [S. cerevisiae]) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; known familial variants	Prior Authorization Required	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing

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81319	PMS2 (postmeiotic segregation increased 2 [S. cerevisiae]) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; duplication/deletion variants	Prior Authorization Required	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
81320	PLCG2 (phospholipase C gamma 2) (eg, chronic lymphocytic leukemia) gene analysis, common variants (eg, R665W, S707F, L845F)	Prior Authorization Required	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
81321	PTEN (phosphatase and tensin homolog) (eg, Cowden syndrome, PTEN hamartoma tumor syndrome) gene analysis; full sequence analysis	Prior Authorization Required	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
81322	PTEN (phosphatase and tensin homolog) (eg, Cowden syndrome, PTEN hamartoma tumor syndrome) gene analysis; known familial variant	Prior Authorization Required	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
81323	PTEN (phosphatase and tensin homolog) (eg, Cowden syndrome, PTEN hamartoma tumor syndrome) gene analysis; duplication/deletion variant	Prior Authorization Required	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing

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81327	SEPT9 (Septin9) (eg, colorectal cancer) promoter methylation analysis	Prior Authorization Required	Investigative	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
81328	SLCO1B1 (solute carrier organic anion transporter family, member 1B1) (eg, adverse drug reaction), gene analysis, common variant(s) (eg, *5)	Prior Authorization Required	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
81329	SMN1 (survival of motor neuron 1, telomeric) (eg, spinal muscular atrophy) gene analysis; dosage/deletion analysis (eg, carrier testing), includes SMN2 (survival of motor neuron 2, centromeric) analysis, if performed	Prior Authorization Required	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
81330	SMPD1(sphingomyelin phosphodiesterase 1, acid lysosomal) (eg, Niemann-Pick disease, Type A) gene analysis, common variants (eg, R496L, L302P, fsP330)	Prior Authorization Required	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
81333	TGFBI (transforming growth factor beta-induced) (eg, corneal dystrophy) gene analysis, common variants (eg, R124H, R124C, R124L, R555W, R555Q)	Prior Authorization Required	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing

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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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
81335	TPMT (thiopurine S-methyltransferase) (eg, drug metabolism), gene analysis, common variants (eg, *2, *3)	Prior Authorization Required	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
81336	SMN1 (survival of motor neuron 1, telomeric) (eg, spinal muscular atrophy) gene analysis; full gene sequence	Prior Authorization Required	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
81337	SMN1 (survival of motor neuron 1, telomeric) (eg, spinal muscular atrophy) gene analysis; known familial sequence variant(s)	Prior Authorization Required	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
81338	MPL (MPL proto-oncogene, thrombopoietin receptor) (eg, myeloproliferative disorder) gene analysis; common variants (eg, W515A, W515K, W515L, W515R)	Prior Authorization Required	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
81339	MPL (MPL proto-oncogene, thrombopoietin receptor) (eg, myeloproliferative disorder) gene analysis; sequence analysis, exon 10	Prior Authorization Required	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing

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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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
81342	TRG@ (T cell antigen receptor, gamma) (eg, leukemia and lymphoma), gene rearrangement analysis, evaluation to detect abnormal clonal population(s)	Prior Authorization Required	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
81343	PPP2R2B (protein phosphatase 2 regulatory subunit Bbeta) (eg, spinocerebellar ataxia) gene analysis, evaluation to detect abnormal (eg, expanded) alleles	Prior Authorization Required	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
81344	TBP (TATA box binding protein) (eg, spinocerebellar ataxia) gene analysis, evaluation to detect abnormal (eg, expanded) alleles	Prior Authorization Required	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
81345	TERT (telomerase reverse transcriptase) (eg, thyroid carcinoma, glioblastoma multiforme) gene analysis, targeted sequence analysis (eg, promoter region)	Prior Authorization Required	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
81346	TYMS (thymidylate synthetase) (eg, 5-fluorouracil/5-FU drug metabolism), gene analysis, common variant(s) (eg, tandem repeat variant)	Prior Authorization Required	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing

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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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
81350	UGT1A1 (UDP glucuronosyltransferase 1 family, polypeptide A1) (eg, drug metabolism, hereditary unconjugated hyperbilirubinemia [gilbert syndrome]) gene analysis, common variants (eg, *28, *36, *37)	Prior Authorization Required	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
81351	TP53 (tumor protein 53) (eg, Li-Fraumeni syndrome) gene analysis; full gene sequence	Prior Authorization Required	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
81352	TP53 (tumor protein 53) (eg, Li-Fraumeni syndrome) gene analysis; targeted sequence analysis (eg, 4 oncology)	Prior Authorization Required	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
81353	TP53 (tumor protein 53) (eg, Li-Fraumeni syndrome) gene analysis; known familial variant	Prior Authorization Required	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
81355	VKORC1 (vitamin K epoxide reductase complex, subunit 1) (e.g., warfarin metabolism), gene analysis, common variants (e.g., -1639/3673)*	Prior Authorization Required	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing

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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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
81361	HBB (hemoglobin, subunit beta) (eg, sickle cell anemia, beta thalassemia, hemoglobinopathy); common variant(s) (eg, HbS, HbC, HbE)	Prior Authorization Required	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
81362	HBB (hemoglobin, subunit beta) (eg, sickle cell anemia, beta thalassemia, hemoglobinopathy); known familial variant(s)	Prior Authorization Required	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
81363	HBB (hemoglobin, subunit beta) (eg, sickle cell anemia, beta thalassemia, hemoglobinopathy); duplication/deletion variant(s)	Prior Authorization Required	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
81364	HBB (hemoglobin, subunit beta) (eg, sickle cell anemia, beta thalassemia, hemoglobinopathy); full gene sequence	Prior Authorization Required	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing

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81402	Molecular pathology procedure, Level 3 (eg, >10 SNPs, 2-10 methylated variants, or 2-10 somatic variants [typically using non-sequencing target variant analysis], immunoglobulin and T-cell receptor gene rearrangements, duplication/deletion variants of 1 exon, loss of heterozygosity [LOH], uniparental disomy [UPD])	Prior Authorization Required	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing

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81407	Molecular pathology procedure, Level 8 (eg, analysis of 26-50 exons by DNA sequence analysis, mutation scanning or duplication/deletion variants of >50 exons, sequence analysis of multiple genes on one platform)	Prior Authorization Required	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
81408	Molecular pathology procedure, Level 9 (eg, analysis of >50 exons in a single gene by DNA sequence analysis)	Prior Authorization Required	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing

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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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
81415	Exome (eg, unexplained constitutional or heritable disorder or syndrome); sequence analysis	Prior Authorization Required	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing

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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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
81420	Fetal chromosomal aneuploidy (eg, trisomy 21, monosomy X) genomic sequence analysis panel, circulating cell-free fetal DNA in maternal blood, must include analysis of chromosomes 13, 18, and 21	Prior Authorization Required	Medical Necessity	History and physical, and chart notes from ordering provider with reason for genetic testing. Note: For Blue Focus, medical necessity review will be performed upon claims submission with supporting documentation
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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
81425	Genome (eg, unexplained constitutional or heritable disorder or syndrome); sequence analysis	Prior Authorization Required	Investigative	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
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	Investigative	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
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	Investigative	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing

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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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing

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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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
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	Investigative	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing

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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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
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	Investigative	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing

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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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
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	Investigative	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
81457	Solid organ neoplasm, genomic sequence analysis panel, interrogation for sequence variants, DNA analysis, microsatellite instability	Prior Authorization Required	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
81458	Solid organ neoplasm, genomic sequence analysis panel, interrogation for sequence variants; DNA analysis, copy number variants and microsatellite instability	Prior Authorization Required	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
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	Investigative	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
81465	Whole mitochondrial genome large deletion analysis panel (eg, Kearns-Sayre syndrome, chronic progressive external ophthalmoplegia), including heteroplasmy detection, if performed	Prior Authorization Required	Investigative	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
81479	Unlisted molecular pathology procedure	Prior Authorization Required	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
81490	Autoimmune (rheumatoid arthritis), analysis of 12 biomarkers using immunoassays, utilizing serum, prognostic algorithm reported as a disease activity score	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, and documentation to support reason for testing
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	Medical Necessity	History and physical, and documentation to support reason for testing

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81500	Oncology (ovarian), biochemical assays of two proteins (CA-125 and HE4), utilizing serum, with menopausal status, algorithm reported as a risk score	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, current treatment plan, and reason for testing
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	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, current treatment plan, and reason for testing
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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
81506	Endocrinology (type 2 diabetes), biochemical assays of seven analytes (glucose, HbA1c, insulin, hs-CRP, adiponectin, ferritin, interleukin 2-receptor alpha), utilizing serum or plasma, algorithm reporting a risk score	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, current treatment plan, and reason for testing
81507	Fetal aneuploidy (trisomy 21, 18, and 13) DNA sequence analysis of selected regions using maternal plasma, algorithm reported as a risk score for each trisomy	Prior Authorization Required	Medical Necessity	History and physical, current treatment plan, and reason for testing
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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing

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81528	Oncology (colorectal) screening, quantitative real-time target and signal amplification of 10 DNA markers (KRAS mutations, promoter methylation of NDRG4 and BMP3) and fecal hemoglobin, utilizing stool, algorithm reported as a positive or negative result	Prior Authorization Required	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
81535	Oncology (gynecologic), live tumor cell culture and chemotherapeutic response by DAPI stain and morphology, predictive algorithm reported as a drug response score; first single drug or drug combination	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, documentation of medical necessity, treatment plan
81536	Oncology (gynecologic), live tumor cell culture and chemotherapeutic response by DAPI stain and morphology, predictive algorithm reported as a drug response score; each additional single drug or drug combination (List separately in addition to code for primary procedure)	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, documentation of medical necessity, treatment plan
81538	Oncology (lung), mass spectrometric 8-protein signature, including amyloid A, utilizing serum, prognostic and predictive algorithm reported as good versus poor overall survival	Advance Benefit Determination (ABD) recommended	Investigative	History and physical, documentation of medical necessity, treatment plan

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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	Advance Benefit Determination (ABD) recommended	Investigative	History and physical, and documentation to support reason for testing
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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
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	Investigative	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing

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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	Investigative	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
81560	Transplantation medicine (allograft rejection, pediatric liver and small bowel), measurement of donor and third-party-induced CD154+T-cytotoxic memory cells, utilizing whole peripheral blood, algorithm reported as a rejection risk score	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, and documentation to support reason for testing
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	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing

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81596	Infectious disease, chronic hepatitis C virus (HCV) infection, six biochemical assays (ALT, A2-macroglobulin, apolipoprotein A-1, total bilirubin, GGT, and haptoglobin) utilizing serum, prognostic algorithm reported as scores for fibrosis and necroinflammatory activity in liver	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, and documentation to support reason for testing
81599	Unlisted multianalyte assay with algorithmic analysis	Prior Authorization Required	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
82233	Beta-amyloid; 1-40 (Abeta 40)	Pre-Service Review Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
82234	Beta-amyloid; 1-42 (Abeta 42)	Pre-Service Review Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
82710	Fat or lipids, feces; quantitative	Advance Benefit Determination (ABD) recommended	Investigative	Submit history, physical, lab report and documentation of medical necessity
82715	Fat differential, feces, quantitative	Advance Benefit Determination (ABD) recommended	Investigative	Submit history, physical, lab report and documentation of medical necessity
83520	Immunoassay for analyte other than infectious agent antibody or infectious agent antigen; quantitative, not otherwise specified	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, documentation with medical necessity and procedure report
83884	Neurofilament light chain (NfL)	Prior Authorization Required	Medical Necessity	History and physical, and chart notes from ordering provider with reason for testing. Note: For Blue Focus, medical necessity review will be performed upon claims submission with supporting documentation

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84393	Tau, phosphorylated (eg, pTau 181, pTau 217), each	Prior Authorization Required	Medical Necessity	History and physical, and chart notes from ordering provider with reason for testing. Note: For Blue Focus, medical necessity review will be performed upon claims submission with supporting documentation
84394	Tau, total (tTau)	Prior Authorization Required	Medical Necessity	History and physical, and chart notes from ordering provider with reason for testing. Note: For Blue Focus, medical necessity review will be performed upon claims submission with supporting documentation
84999	Unlisted chemistry procedure	Advance Benefit Determination (ABD) recommended	Medical Necessity	Office notes from ordering provider related to study/service and provide documentation to describe service
85999	Unlisted hematology and coagulation procedure	Advance Benefit Determination (ABD) recommended	Medical Necessity	Office notes from ordering provider related to study/service and provide documentation to describe service
86152	Cell enumeration using immunologic selection and identification in fluid specimen (eg, circulating tumor cells in blood);	Advance Benefit Determination (ABD) recommended	Investigative	Submit history and physical, documentation of medical necessity and procedure report.
86153	Cell enumeration using immunologic selection and identification in fluid specimen (eg, circulating tumor cells in blood); physician interpretation and report, when required	Advance Benefit Determination (ABD) recommended	Investigative	Submit history and physical, documentation of medical necessity and procedure report.
86352	Cellular function assay involving stimulation (eg, mitogen or antigen) and detection of biomarker (eg, ATP)	Advance Benefit Determination (ABD) recommended	Investigative	Submit procedure/testing report
86486	Unlisted antigen, skin test, each	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history and physical, documentation of medical necessity.
86849	Unlisted immunology procedure	Advance Benefit Determination (ABD) recommended	Medical Necessity	Office notes from ordering provider related to study/service and provide documentation to describe service

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86999	Unlisted transfusion medicine procedure	Advance Benefit Determination (ABD) recommended	Medical Necessity	Office notes from ordering provider related to study/service and provide documentation to describe service
87003	Animal inoculation, small animal, with observation and dissection	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
87487	Infectious agent detection by nucleic acid (DNA or RNA); Chlamydia pneumoniae, quantification	Advance Benefit Determination (ABD) recommended	Investigative	Submit history, physical, lab report and documentation of medical necessity
87505	Infectious agent detection by nucleic acid (DNA or RNA); gastrointestinal pathogen (eg, Clostridium difficile, E. coli, Salmonella, Shigella, norovirus, Giardia), includes multiplex reverse transcription, when performed, and multiplex amplified probe technique, multiple types or subtypes, 3-5 targets	Advance Benefit Determination (ABD) recommended	Investigative	Submit history, physical, lab report and documentation of medical necessity
87506	Infectious agent detection by nucleic acid (DNA or RNA); gastrointestinal pathogen (eg, Clostridium difficile, E. coli, Salmonella, Shigella, norovirus, Giardia), includes multiplex reverse transcription, when performed, and multiplex amplified probe technique, multiple types or subtypes, 6-11 targets	Advance Benefit Determination (ABD) recommended	Investigative	Submit history, physical, lab report and documentation of medical necessity
87507	Infectious agent detection by nucleic acid (DNA or RNA); gastrointestinal pathogen (eg, Clostridium difficile, E. coli, Salmonella, Shigella, norovirus, Giardia), includes multiplex reverse transcription, when performed, and multiplex amplified probe technique, multiple types or subtypes, 12-25 targets	Advance Benefit Determination (ABD) recommended	Investigative	Submit history, physical, lab report and documentation of medical necessity
87525	Infectious agent detection by nucleic acid (DNA or RNA); hepatitis G, direct probe technique	Advance Benefit Determination (ABD) recommended	Investigative	Submit history, physical, lab report and documentation of medical necessity

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
87526	Infectious agent detection by nucleic acid (DNA or RNA); hepatitis G, amplified probe technique	Advance Benefit Determination (ABD) recommended	Investigative	Submit history, physical, lab report and documentation of medical necessity
87527	Infectious agent detection by nucleic acid (DNA or RNA); hepatitis G, quantification	Advance Benefit Determination (ABD) recommended	Investigative	Submit history, physical, lab report and documentation of medical necessity
87797	Nucleic acid detection; not otherwise specified, by direct probe	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, and documentation of medical necessity, including the reason for testing
87798	Nucleic acid detection; not otherwise specified, by amplified probe	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, and documentation of medical necessity, including the reason for testing
87799	Nucleic acid detection; not otherwise specified, quantification	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, and documentation of medical necessity, including the reason for testing
87999	Unlisted microbiology procedure	Advance Benefit Determination (ABD) recommended	Medical Necessity	Office notes from ordering provider related to study/service and provide documentation to describe service
88000	Necropsy (autopsy), gross examination only; without CNS	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
88005	Necropsy (autopsy), gross examination only; with brain	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
88007	Necropsy (autopsy), gross examination only; with brain and spinal cord	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
88012	Necropsy (autopsy), gross examination only; infant with brain	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
88014	Necropsy (autopsy), gross examination only; stillborn or newborn with brain	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
88016	Necropsy (autopsy), gross examination only; macerated stillborn	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
88020	Necropsy (autopsy), gross and microscopic; without CNS	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
88025	Necropsy (autopsy), gross and microscopic; with brain	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.

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88027	Necropsy (autopsy), gross and microscopic; infant with brain	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
88028	Necropsy (autopsy), gross and microscopic; infant with brain	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
88029	Necropsy (autopsy), gross and microscopic; stillborn or newborn with brain	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
88036	Necropsy (autopsy), limited, gross and/or microscopic; regional	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
88037	Necropsy (autopsy), limited, gross and/or microscopic; single organ	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
88040	Necropsy (autopsy); forensic examination	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
88045	Necropsy (autopsy); coroner's call	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
88099	Unlisted necropsy (autopsy) procedure	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
88199	Unlisted cytopathology procedure	Advance Benefit Determination (ABD) recommended	Medical Necessity	Office notes from ordering provider related to study/service and provide documentation to describe service
88240	Cryopreservation, freezing and storage of cells, each cell line	Advance Benefit Determination (ABD) recommended	Medical Necessity	Chart notes from the ordering provider with reason for cryopreservation
88241	Thawing and expansion of frozen cells, each aliquot	Advance Benefit Determination (ABD) recommended	Medical Necessity	Chart notes from the ordering provider with reason for cryopreservation
88245	Chromosome analysis for breakage syndromes; baseline Sister Chromatid Exchange (SCE), 20-25 cells	Prior Authorization Required	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
88248	Chromosome analysis for breakage syndromes; baseline breakage, score 50-100 cells, count 20 cells, 2 karyotypes (eg, for ataxia telangiectasia, Fanconi anemia, fragile X)	Prior Authorization Required	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing

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88249	Chromosome analysis for breakage syndromes; score 100 cells, clastogen stress (eg, diepoxybutane, mitomycin C, ionizing radiation, UV radiation)	Prior Authorization Required	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
88261	Chromosome analysis; count 5 cells, 1 karyotype, with banding	Prior Authorization Required	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
88262	Chromosome analysis; count 15-20 cells, 2 karyotypes, with banding	Prior Authorization Required	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
88263	Chromosome analysis; count 45 cells for mosaicism, 2 karyotypes, with banding	Prior Authorization Required	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
88264	Chromosome analysis; analyze 20-25 cells	Prior Authorization Required	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
88271	Molecular cytogenetics; DNA probe, each (eg, FISH)	Prior Authorization Required	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
88272	Molecular cytogenetics; chromosomal in situ hybridization, analyze 3-5 cells (eg, for derivatives and markers)	Prior Authorization Required	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
88273	Molecular cytogenetics; chromosomal in situ hybridization, analyze 10-30 cells (eg, for microdeletions)	Prior Authorization Required	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
88274	Molecular cytogenetics; interphase in situ hybridization, analyze 25-99 cells	Prior Authorization Required	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing

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88275	Molecular cytogenetics; interphase in situ hybridization, analyze 100-300 cells	Prior Authorization Required	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
88280	Chromosome analysis; additional karyotypes, each study	Prior Authorization Required	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
88283	Chromosome analysis; additional specialized banding technique (eg, NOR, C-banding)	Prior Authorization Required	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
88285	Chromosome analysis; additional cells counted, each study	Prior Authorization Required	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
88289	Chromosome analysis; additional high resolution study	Prior Authorization Required	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
88291	Cytogenetics and molecular cytogenetics, interpretation and report	Prior Authorization Required	Medical Necessity	History and physical, and documentation of medical necessity, and chart notes from ordering provider with reason for testing
88299	Unlisted cytogenetic study	Advance Benefit Determination (ABD) recommended	Medical Necessity	Office notes from ordering provider related to study/service and provide documentation to describe service
88375	Optical endomicroscopic image(s), interpretation and report, real-time or referred, each endoscopic session	Advance Benefit Determination (ABD) recommended	Investigative	Submit procedure/testing report
88399	Unlisted surgical pathology procedure	Advance Benefit Determination (ABD) recommended	Medical Necessity	Office notes from ordering provider related to study/service and provide documentation to describe service
88749	Unlisted in vivo lab service	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history and physical, documentation of medical necessity.

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89160	Meat fibers, feces	Advance Benefit Determination (ABD) recommended	Investigative	Submit history, physical, lab report and documentation of medical necessity
89240	Unlisted miscellaneous pathology test	Advance Benefit Determination (ABD) recommended	Medical Necessity	Office notes from ordering provider related to study/service and provide documentation to describe service
89250	Culture of oocyte(s)/embryo(s), less than 4 days;	Prior Authorization Required	Potential Contract Exclusion	History and physical, and documentation of infertility, including treatment plan
89251	Culture of oocyte(s)/embryo(s), less than 4 days; with co-culture of oocyte(s)/embryos	Non-covered Service	Not Covered	Considered non-covered when identified as IVF service
89253	Assisted embryo hatching, microtechniques (any method)	Prior Authorization Required	Potential Contract Exclusion	History and physical, and documentation of infertility, including treatment plan
89254	Oocyte identification from follicular fluid	Prior Authorization Required	Potential Contract Exclusion	History and physical, and documentation of infertility, including treatment plan
89255	Preparation of embryo for transfer (any method)	Prior Authorization Required	Potential Contract Exclusion	History and physical, and documentation of infertility, including treatment plan
89257	Sperm identification from aspiration (other than seminal fluid)	Non-covered Service	Not Covered	Considered non-covered when identified as IVF service
89257	Sperm identification from aspiration (other than seminal fluid)	Prior Authorization Required	Medical Necessity	History and Physical, documentation of medical necessity NOTE: Claims for this drug are processed through the Local Plan, not pharmacy.
89258	Cryopreservation; embryo(s)	Prior Authorization Required	Potential Contract Exclusion	History and physical, and documentation of infertility, including treatment plan
89259	Cryopreservation; sperm	Non-covered Service	Not Covered	Considered non-covered when identified as IVF service
89260	Sperm isolation; simple prep (eg, sperm wash and swim-up) for insemination or diagnosis with semen analysis	Non-covered Service	Not Covered	Considered non-covered when identified as IVF service

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89261	Sperm isolation; complex prep (eg, Percoll gradient, albumin gradient) for insemination or diagnosis with semen analysis	Prior Authorization Required	Potential Contract Exclusion	History and physical, and documentation of infertility, including treatment plan
89264	Sperm identification from testis tissue, fresh or cryopreserved	Non-covered Service	Not Covered	Considered non-covered when identified as IVF service
89268	Insemination of oocytes	Non-covered Service	Not Covered	Considered non-covered when identified as IVF service
89272	Extended culture of oocyte(s)/embryo(s), 4-7 days	Prior Authorization Required	Potential Contract Exclusion	History and physical, and documentation of infertility, including treatment plan
89280	Assisted oocyte fertilization, microtechnique; less than or equal to 10 oocytes	Prior Authorization Required	Potential Contract Exclusion	History and physical, and documentation of infertility, including treatment plan
89281	Assisted oocyte fertilization, microtechnique; greater than 10 oocytes	Prior Authorization Required	Potential Contract Exclusion	History and physical, and documentation of infertility, including treatment plan
89290	Biopsy, oocyte polar body or embryo blastomere, microtechnique (for pre-implantation genetic diagnosis); less than or equal to 5 embryos	Prior Authorization Required	Potential Contract Exclusion	History and physical, and documentation of infertility, including treatment plan
89291	Biopsy, oocyte polar body or embryo blastomere, microtechnique (for pre-implantation genetic diagnosis); greater than 5 embryos	Prior Authorization Required	Potential Contract Exclusion	History and physical, and documentation of infertility, including treatment plan
89335	Cryopreservation, reproductive tissue, testicular	Non-covered Service	Not Covered	Considered non-covered when identified as IVF service
89337	Cryopreservation, mature oocyte(s)	Non-covered Service	Not Covered	Considered non-covered when identified as IVF service
89342	Storage (per year); embryo(s)	Prior Authorization Required	Potential Contract Exclusion	History and physical, and documentation of infertility, including treatment plan
89343	Storage (per year); sperm/semen	Prior Authorization Required	Potential Contract Exclusion	History and physical, and documentation of infertility, including treatment plan
89344	Storage (per year); reproductive tissue, testicular/ovarian	Non-covered Service	Not Covered	Considered non-covered when identified as IVF service

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89346	Storage (per year); oocyte(s)	Prior Authorization Required	Potential Contract Exclusion	History and physical, and documentation of infertility, including treatment plan
89352	Thawing of cryopreserved; embryo(s)	Non-covered Service	Not Covered	Considered non-covered when identified as IVF service
89353	Thawing of cryopreserved; sperm/semen, each aliquot	Non-covered Service	Not Covered	Considered non-covered when identified as IVF service
89356	Thawing of cryopreserved; oocytes, each aliquot	Prior Authorization Required	Potential Contract Exclusion	History and physical, and documentation of infertility, including treatment plan
89398	Unlisted reproductive medicine laboratory procedure	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical and description of service(s) provided
90281	Immune globulin (Ig), human, for intramuscular use	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history, physical, lab report and documentation of medical necessity
90283	Immune globulin (IgIV), human, for intravenous use	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history, physical, lab report and documentation of medical necessity
90284	Immune globulin (SCIg), human, for use in subcutaneous infusions, 100 mg, each	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history, physical, lab report and documentation of medical necessity
90288	Botulism Immune Globulin	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, demonstrating reason for requested medication, lab work (if applicable), dosage and duration of treatment, office notes related to condition, documentation of medical necessity and documentation of previous therapies that were tried and failed
90393	Vaccinia immune globulin, human, for intramuscular use	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history and physical, documentation of medical necessity.
90399	Unlisted immune globulin	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history and physical, documentation of medical necessity.
90584	Dengue vaccine, quadrivalent, live, 2 dose schedule, for subcutaneous use	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.

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90587	Dengue vaccine, quadrivalent, live, 3 dose schedule, for subcutaneous use	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	Submit history and physical, documentation of medical necessity.
90593	Chikungunya virus vaccine, recombinant, for intramuscular use	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
90624	Meningococcal pentavalent vaccine, Men B-4C recombinant proteins and outer membrane vesicle and conjugated Men A, C, W, Y-diphtheria toxoid carrier, for intramuscular use	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
90637	Influenza virus vaccine, quadrivalent (qIRV), mRNA; 30 mcg/0.5 mL dosage, for intramuscular use	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
90638	Influenza virus vaccine, quadrivalent (qIRV), mRNA; 60 mcg/0.5 mL dosage, for intramuscular use	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
90666	Influenza virus vaccine (IIV), pandemic formulation, split virus, preservative free, for intramuscular use	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
90667	Influenza virus vaccine (IIV), pandemic formulation, split virus, adjuvanted, for intramuscular use	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
90668	Influenza virus vaccine (IIV), pandemic formulation, split virus, for intramuscular use	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
90695	Influenza virus vaccine, H5N8, derived from cell cultures, adjuvanted, for intramuscular use	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
90749	Unlisted vaccine/toxoid	Advance Benefit Determination (ABD) recommended	Medical Necessity	Office notes specifying the reason for billed services, as well as documentation to describe the services
90758	Zaire ebolavirus vaccine, live, for intramuscular use	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history and physical, documentation of medical necessity.

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90867	Therapeutic repetitive transcranial magnetic stimulation treatment; planning	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history and physical, documentation of medical necessity and procedure report; no review needed if member has a diagnosis of depression.
90868	Therapeutic repetitive transcranial magnetic stimulation treatment; delivery and management, per session	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history and physical, documentation of medical necessity and procedure report; no review needed if member has a diagnosis of depression.
90869	Therapeutic repetitive transcranial magnetic stimulation (TMS) treatment; subsequent motor threshold re-determination with delivery and management	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history and physical, documentation of medical necessity and procedure report; no review needed if member has a diagnosis of depression.
90875	Individual psychophysiological therapy incorporating biofeedback training by any modality (face-to-face with the patient), with psychotherapy (eg, insight oriented, behavior modifying or supportive psychotherapy); approximately 20-30 minutes	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
90876	Individual psychophysiological therapy incorporating biofeedback training by any modality (face-to-face with the patient), with psychotherapy (eg, insight oriented, behavior modifying or supportive psychotherapy); approximately 45-50 minutes	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
90882	Environmental intervention for medical management purposes on a psychiatric patient's behalf with agencies, employers, or institutions	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
90885	PSYCHIATRIC EVALUATION OF HOSPITAL RECORDS, OTHER PSYCHIATRI	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.

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90899	Unlisted psychiatric service or procedure	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit documentation to describe the services provided along with a summary of symptoms and functional impairments related to that service
90901	Biofeedback training by any modality	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
90912	Biofeedback training, perineal muscles, anorectal or urethral sphincter, including EMG and/or manometry, when performed; initial 15 minutes of one-on-one physician or other qualified health care professional contact with the patient	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
90913	Biofeedback training, perineal muscles, anorectal or urethral sphincter, including EMG and/or manometry, when performed; each additional 15 minutes of one-on-one physician or other qualified health care professional contact with the patient (List separately in addition to code for primary procedure)	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
91110	Gastrointestinal tract imaging, intraluminal (eg, capsule endoscopy), esophagus through ileum, with physician interpretation and report	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical and results of previous diagnostic procedure report
91111	Gastrointestinal tract imaging, intraluminal (eg, capsule endoscopy), esophagus with physician interpretation and report	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical and results of previous diagnostic procedure report
91113	Gastrointestinal tract imaging, intraluminal (eg, capsule endoscopy), colon, with interpretation and report	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history and physical, documentation of medical necessity.
91299	Unlisted diagnostic gastroenterology procedure	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, including documentation to describe services/procedure performed

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92132	Scanning computerized ophthalmic diagnostic imaging (eg, optical coherence tomography (OCT)), anterior segment, with interpretation and report, unilateral or bilateral	Advance Benefit Determination (ABD) recommended	Investigative	Submit procedure/testing report
92326	Replacement of contact lens	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
92370	Repair and refitting spectacles; except for aphakia	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
92371	Repair and refitting spectacles; spectacle prosthesis for aphakia	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
92499	Unlisted eye procedure	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, including documentation to describe services/procedure performed
92592	Hearing aid check; monaural	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
92593	Hearing aid check; binaural	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
92597	Evaluation for use and/or fitting of voice prosthetic device to supplement oral speech	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
92625	Assessment of tinnitus (includes pitch, loudness matching, and masking)	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
92634	Hearing aid fitting services, unilateral or bilateral, including device analysis, programming, verification, counseling, orientation, and training, and, when performed, hearing assistive device, supplemental technology fitting services; first 60 minutes	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.

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92635	Hearing aid fitting services, unilateral or bilateral, including device analysis, programming, verification, counseling, orientation, and training, and, when performed, hearing assistive device, supplemental technology fitting services; each additional 15 minutes (List separately in addition to code for primary procedure)	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
92636	Hearing aid post-fitting follow-up services, unilateral or bilateral, including confirmation of physical fit, validation of patient benefit and performance, sound quality of device, adjustment(s) (eg, verification, programming adjustment[s], device connection[s], and device training), as indicated, and, when performed, hearing assistive device, supplemental technology fitting services; first 30 minutes	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
92637	Hearing aid post-fitting follow-up services, unilateral or bilateral, including confirmation of physical fit, validation of patient benefit and performance, sound quality of device, adjustment(s) (eg, verification, programming adjustment[s], device connection[s], and device training), as indicated, and, when performed, hearing assistive device, supplemental technology fitting services; each additional 15 minutes (List separately in addition to code for primary procedure)	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.

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92638	Behavioral verification of amplification including aided thresholds, functional gain, speech-in-noise, when performed (List separately in addition to code for primary procedure)	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
92639	Hearing-aid measurement, verification with probe-microphone (List separately in addition to code for primary procedure)	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
92641	Hearing device verification, electroacoustic analysis	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
92642	Hearing assistive device, supplemental technology fitting services (eg, personal frequency modulation [FM]/digital modulation [DM] system, remote microphone, alerting devices)	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
92700	Unlisted otorhinolaryngological service or procedure	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, and documentation of medical necessity, as well as description of service(s) performed
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	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, documentation of medical necessity, and previous ambulatory event monitor use

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Code List

Code	Description	Plan Review Requirement	Reviewed For	Records Request
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	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, documentation of medical necessity, and previous ambulatory event monitor use
93241	External electrocardiographic recording for more than 48 hours up to 7 days by continuous rhythm recording and storage; includes recording, scanning analysis with report, review and interpretation	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, documentation of medical necessity, and previous ambulatory event monitor use
93242	External electrocardiographic recording for more than 48 hours up to 7 days by continuous rhythm recording and storage; recording (includes connection and initial recording)	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	Submit procedure/testing report
93243	External electrocardiographic recording for more than 48 hours up to 7 days by continuous rhythm recording and storage; scanning analysis with report	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	Submit procedure/testing report
93244	External electrocardiographic recording for more than 48 hours up to 7 days by continuous rhythm recording and storage; review and interpretation	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	Submit procedure/testing report

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
93245	External electrocardiographic recording for more than 7 days up to 15 days by continuous rhythm recording and storage; includes recording, scanning analysis with report, review and interpretation	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, documentation of medical necessity, and previous ambulatory event monitor use
93246	External electrocardiographic recording for more than 7 days up to 15 days by continuous rhythm recording and storage; recording (includes connection and initial recording)	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, documentation of medical necessity, and previous ambulatory event monitor use
93247	External electrocardiographic recording for more than 7 days up to 15 days by continuous rhythm recording and storage; scanning analysis with report	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, documentation of medical necessity, and previous ambulatory event monitor use
93248	External electrocardiographic recording for more than 7 days up to 15 days by continuous rhythm recording and storage; review and interpretation	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, documentation of medical necessity, and previous ambulatory event monitor use
93268	External patient and, when performed, auto activated electrocardiographic rhythm derived event recording with symptom-related memory loop with remote download capability up to 30 days, 24-hour attended monitoring; includes transmission, review and interpretation by a physician or other qualified health care professional	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, documentation of medical necessity, and previous ambulatory event monitor use
93270	External patient and, when performed, auto activated electrocardiographic rhythm derived event recording with symptom-related memory loop with remote download capability up to 30 days, 24-hour attended monitoring; recording (includes connection, recording, and disconnection)	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, documentation of medical necessity, and previous ambulatory event monitor use

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
93285	Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed VALUES with analysis, review and report by a physician or other qualified health care professional; subcutaneous cardiac rhythm monitor system	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, documentation of medical necessity, and previous ambulatory event monitor use
93291	Interrogation device evaluation (in person) with analysis, review and report by a physician or other qualified health care professional, includes connection, recording and disconnection per patient encounter; subcutaneous cardiac rhythm monitor system, including heart rhythm derived data analysis	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, documentation of medical necessity, and previous ambulatory event monitor use
93298	Interrogation device evaluation(s), (remote) up to 30 days; subcutaneous cardiac rhythm monitor system, including analysis of recorded heart rhythm data, analysis, review(s) and report(s) by a physician or other qualified health care professional	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, documentation of medical necessity, and previous ambulatory event monitor use
93356	Myocardial strain imaging using speckle tracking-derived assessment of myocardial mechanics (List separately in addition to codes for echocardiography imaging)	Advance Benefit Determination (ABD) recommended	Investigative	History and physical, documentation of medical necessity, and procedure report
93580	Percutaneous transcatheter closure of congenital interatrial communication (ie, fonton fenestration, atrial septal defect) with implant	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history,physical and operative report

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
93581	Percutaneous transcatheter closure of congenital ventricular septal defect with implant(Percutaneous transcatheter closure of ventricular septal defect (i.e fontan fenestration) includes a right heart catheterization procedure. Code 93581includes injectio	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history,physical and operative report
93582	Percutaneous transcatheter closure of patent ductus arteriosus	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, and procedure report, including the name of the transcatheter device used. medical necessity review will be performed upon claims submission with supporting documentation
93609	Intraventricular and/or intra-atrial mapping of tachycardia site(s) with catheter manipulation to record from multiple sites to identify origin of tachycardia (List separately in addition to code for primary procedure)	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
93613	Intracardiac electrophysiologic 3-dimensional mapping (List separately in addition to code for primary procedure)	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
93619	Comprehensive electrophysiologic evaluation with right atrial pacing and recording, right ventricular pacing and recording, His bundle recording, including insertion and repositioning of multiple electrode catheters, without induction or attempted induction of arrhythmia	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, documentation of medical necessity, and procedure report

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
93620	Comprehensive electrophysiologic evaluation including insertion and repositioning of multiple electrode catheters with induction or attempted induction of arrhythmia; with right atrial pacing and recording, right ventricular pacing and recording, His bundle recording	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
93621	Comprehensive electrophysiologic evaluation including insertion and repositioning of multiple electrode catheters with induction or attempted induction of arrhythmia; with left atrial pacing and recording from coronary sinus or left atrium (List separately in addition to code for primary procedure)	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
93622	Comprehensive electrophysiologic evaluation including insertion and repositioning of multiple electrode catheters with induction or attempted induction of arrhythmia; with left ventricular pacing and recording (List separately in addition to code for primary procedure)	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
93624	Electrophysiologic follow-up study with pacing and recording to test effectiveness of therapy, including induction or attempted induction of arrhythmia	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, documentation of medical necessity, and procedure report

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
93653	Comprehensive electrophysiologic evaluation with insertion and repositioning of multiple electrode catheters, induction or attempted induction of an arrhythmia with right atrial pacing and recording and catheter ablation of arrhythmogenic focus, including intracardiac electrophysiologic 3-dimensional mapping, right ventricular pacing and recording, left atrial pacing and recording from coronary sinus or left atrium, and His bundle recording, when performed; with treatment of supraventricular tachycardia by ablation of fast or slow atrioventricular pathway, accessory atrioventricular connection, cavo-tricuspid isthmus or other single atrial focus or source of atrial re-entry	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
93654	Comprehensive electrophysiologic evaluation with insertion and repositioning of multiple electrode catheters, induction or attempted induction of an arrhythmia with right atrial pacing and recording and catheter ablation of arrhythmogenic focus, including intracardiac electrophysiologic 3-dimensional mapping, right ventricular pacing and recording, left atrial pacing and recording from coronary sinus or left atrium, and His bundle recording, when performed; with treatment of ventricular tachycardia or focus of ventricular ectopy including left ventricular pacing and recording, when performed	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, documentation of medical necessity, and procedure report

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
93655	Intracardiac catheter ablation of a discrete mechanism of arrhythmia which is distinct from the primary ablated mechanism, including repeat diagnostic maneuvers, to treat a spontaneous or induced arrhythmia (List separately in addition to code for primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, pre-op evaluations, heart imaging/testing report(s), operative/procedure report, anesthesia report, and documentation of medical necessity
93656	Comprehensive electrophysiologic evaluation with transseptal catheterizations, insertion and repositioning of multiple electrode catheters, induction or attempted induction of an arrhythmia including left or right atrial pacing/recording, and intracardiac catheter ablation of atrial fibrillation by pulmonary vein isolation, including intracardiac electrophysiologic 3-dimensional mapping, intracardiac echocardiography with imaging supervision and interpretation, right ventricular pacing/recording, and His bundle recording, when performed	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, pre-op evaluations, heart imaging/testing report(s), operative/procedure report, anesthesia report, and documentation of medical necessity
93657	Additional linear or focal intracardiac catheter ablation of the left or right atrium for treatment of atrial fibrillation remaining after completion of pulmonary vein isolation (List separately in addition to code for primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, pre-op evaluations, heart imaging/testing report(s), operative/procedure report, anesthesia report, and documentation of medical necessity
93668	Peripheral arterial disease (PAD) rehabilitation, per session	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
93702	Bioimpedance spectroscopy (BIS), extracellular fluid analysis for lymphedema assessment(s)	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, documentation of medical necessity, and procedure report

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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	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, documentation of medical necessity and plan of care. medical necessity review will be performed upon claims submission with supporting documentation
93797	Physician or other qualified health care professional services for outpatient cardiac rehabilitation; without continuous ECG monitoring (per session)	Prior Authorization Required	Medical Necessity	History and physical, operative report (if applicable), therapy notes and documentation of medical necessity including reasoning for rehab and treatment plan
93798	Physician or other qualified health care professional services for outpatient cardiac rehabilitation; with continuous ECG monitoring (per session)	Prior Authorization Required	Medical Necessity	History and physical, operative report (if applicable), therapy notes and documentation of medical necessity including reasoning for rehab and treatment plan
93799	Unlisted cardiovascular service or procedure	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, including description of specific service/procedure rendered
93895	Quantitative carotid intima media thickness and carotid atheroma evaluation, bilateral	Advance Benefit Determination (ABD) recommended	Investigative	History and physical, documentation of medical necessity, and procedure report
93998	Unlisted noninvasive vascular diagnostic study	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
94625	Physician or other qualified health care professional services for outpatient pulmonary rehabilitation; without continuous oximetry monitoring (per session)	Prior Authorization Required	Medical Necessity	History and physical, operative report (if applicable), therapy notes and documentation of medical necessity including reasoning for rehab and treatment plan
94626	Physician or other qualified health care professional services for outpatient pulmonary rehabilitation; with continuous oximetry monitoring (per session)	Prior Authorization Required	Medical Necessity	History and physical, operative report (if applicable), therapy notes and documentation of medical necessity including reasoning for rehab and treatment plan
94669	Mechanical chest wall oscillation to facilitate lung function, per session	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history and physical, documentation of medical necessity.

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94799	Unlisted pulmonary service or procedure	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, including description of specific service/procedure rendered
95060	Opthalmic mucus membrane tests	Advance Benefit Determination (ABD) recommended	Investigative	Submit history and physical, documentation of medical necessity and procedure report.
95199	Unlisted allergy/clinical immunologic service or procedure	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, including description of specific service/procedure rendered
95782	Polysomnography; younger than 6 years, sleep staging with 4 or more additional parameters of sleep, attended by a technologist	Advance Benefit Determination (ABD) recommended	Medical Necessity	Allow for members ages 17 years and younger
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	Advance Benefit Determination (ABD) recommended	Medical Necessity	Allow for members ages 17 years and younger
95800	Sleep study, unattended, simultaneous recording; heart rate, oxygen saturation, respiratory analysis (eg, by airflow or peripheral arterial tone), and sleep time	Advance Benefit Determination (ABD) recommended	Medical Necessity	No review for members 18 years and older; for members 17 years and younger, submit history and physical, and documentation of medical necessity
95801	Sleep study, unattended, simultaneous recording; minimum of heart rate, oxygen saturation, and respiratory analysis (eg, by airflow or peripheral arterial tone)	Advance Benefit Determination (ABD) recommended	Medical Necessity	No review for members 18 years and older; for members 17 years and younger, submit history and physical, and documentation of medical necessity
95803	Actigraphy testing, recording, analysis, interpretation, and report (minimum of 72 hours to 14 consecutive days of recording)	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history and physical, documentation of medical necessity.

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95805	Multiple sleep latency or maintenance of wakefulness testing, recording, analysis and interpretation of physiological measurements of sleep during multiple trials to assess sleepiness	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history and physical, documentation of medical necessity.
95806	Sleep study, unattended, simultaneous recording of, heart rate, oxygen saturation, respiratory airflow, and respiratory effort (eg, thoracoabdominal movement)	Advance Benefit Determination (ABD) recommended	Medical Necessity	No review for members 18 years and older; for members 17 years and younger, submit history and physical, and documentation of medical necessity
95807	Sleep study, simultaneous recording of ventilation, respiratory effort, ECG or heart rate, and oxygen saturation, attended by a technologist	Advance Benefit Determination (ABD) recommended	Medical Necessity	No review for members 17 years and younger; for members 18 years and older, submit history and physical, documentation of medical necessity for attended sleep study vs home sleep study and procedure report
95808	Polysomnography; sleep staging with 1-3 additional parameters of sleep, attended by a technologist	Advance Benefit Determination (ABD) recommended	Medical Necessity	No review for members 17 years and younger; for members 18 years and older, submit history and physical, documentation of medical necessity for attended sleep study vs home sleep study and procedure report
95810	Polysomnography; sleep staging with 4 or more additional parameters of sleep, attended by a technologist	Advance Benefit Determination (ABD) recommended	Medical Necessity	No review for members 17 years and younger; for members 18 years and older, submit history and physical, documentation of medical necessity for attended sleep study vs home sleep study and 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	Advance Benefit Determination (ABD) recommended	Medical Necessity	No review for members 17 years and younger; for members 18 years and older, submit history and physical, documentation of medical necessity for attended sleep study vs home sleep study and procedure report

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95919	Quantitative pupillometry with physician or other qualified health care professional interpretation and report, unilateral or bilateral	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	Submit procedure/testing report
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)	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history and physical. documentation of medical necessity and procedure report. medical necessity review will be performed upon claims submission with supporting documentation
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)	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history and physical. documentation of medical necessity and procedure report. medical necessity review will be performed upon claims submission with supporting documentation
95980	Electronic analysis of implanted neurostimulator pulse generator system gastric neurostimulator pulse generator/transmitter; intraoperative, with programming	Advance Benefit Determination (ABD) recommended	Investigative	Submit procedure report. medical necessity review will be performed upon claims submission with supporting documentation
95981	Electronic analysis of implanted neurostimulator pulse generator system gastric neurostimulator pulse generator/transmitter; subsequent, without reprogramming	Advance Benefit Determination (ABD) recommended	Investigative	Submit procedure report. medical necessity review will be performed upon claims submission with supporting documentation
95982	Electronic analysis of implanted neurostimulator pulse generator system gastric neurostimulator pulse generator/transmitter; subsequent, with reprogramming	Advance Benefit Determination (ABD) recommended	Investigative	Submit procedure report. medical necessity review will be performed upon claims submission with supporting documentation
95999	Unlisted neurological or neuromuscular diagnostic procedure	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history and physical, documentation of medical necessity, procedure report and description of specific service or procedure provided

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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	Not Covered	Considered non-covered unless member's contract indicates coverage.
96202	Multiple-family group behavior management/modification training for parent(s)/guardian(s)/caregiver(s) of patients with a mental or physical health diagnosis, administered by physician or other qualified health care professional (without the patient present), face-to-face with multiple sets of parent(s)/guardian(s)/caregiver(s); initial 60 minutes	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
96203	Multiple-family group behavior management/modification training for parent(s)/guardian(s)/caregiver(s) of patients with a mental or physical health diagnosis, administered by physician or other qualified health care professional (without the patient present), face-to-face with multiple sets of parent(s)/guardian(s)/caregiver(s); each additional 15 minutes (List separately in addition to code for primary service)	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
96379	Unlisted therapeutic, prophylactic, or diagnostic intravenous or intra-arterial injection or infusion	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history and physical, documentation of medical necessity, procedure report and description of specific service or procedure provided
96549	Unlisted chemotherapy procedure	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history and physical, documentation of medical necessity, procedure report and description of specific service or procedure provided

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96904	Whole body integumentary photography, for monitoring of high risk patients with dysplastic nevus syndrome or a history of dysplastic nevi, or patients with a personal or familial history of melanoma	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
96999	Unlisted special dermatological service or procedure	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history and physical, documentation of medical necessity, procedure report and description of specific service or procedure provided
97039	Unlisted modality (specify type and time if constant attendance)	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit documentation to describe specific services provided; specify procedure performed and treatment plan
97129	Therapeutic interventions that focus on cognitive function (eg, attention, memory, reasoning, executive function, problem solving, and/or pragmatic functioning) and compensatory strategies to manage the performance of an activity (eg, managing time or schedules, initiating, organizing, and sequencing tasks), direct (one-on-one) patient contact; initial 15 minutes	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history and physical, documentation of medical necessity.
97130	Therapeutic interventions that focus on cognitive function (eg, attention, memory, reasoning, executive function, problem solving, and/or pragmatic functioning) and compensatory strategies to manage the performance of an activity (eg, managing time or schedules, initiating, organizing, and sequencing tasks), direct (one-on-one) patient contact; each additional 15 minutes (List separately in addition to code for primary procedure)	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history and physical, documentation of medical necessity.

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97139	Unlisted therapeutic procedure (specify)	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit documentation to describe specific services provided; specify procedure performed and treatment plan
97151	Behavior identification assessment, administered by a physician or other qualified health care professional, each 15 minutes of the physician's or other qualified health care professional's time face-to-face with patient and/or guardian(s)/caregiver(s) administering assessments and discussing findings and recommendations, and non-face-to-face analyzing past data, scoring/interpreting the assessment, and preparing the report/treatment plan	Prior Authorization Required	Medical Necessity Review Required	For initial treatment: Submit clinical records including verification that autism spectrum disorder diagnosis was made by appropriate diagnosing provider, copy of functional behavioral assessment, treatment plan - including location of services and current Individualized Education Plan. For ongoing treatment: Submit clinical records that include the recent behavioral re-assessment, treatment plan update - including location of services and current Individualized Education Plan.
97153	Adaptive behavior treatment by protocol, administered by technician under the direction of a physician or other qualified health care professional, face-to-face with one patient, each 15 minutes	Prior Authorization Required	Medical Necessity Review Required	For initial treatment: Submit clinical records including verification that autism spectrum disorder diagnosis was made by appropriate diagnosing provider, copy of functional behavioral assessment, treatment plan - including location of services and current Individualized Education Plan. For ongoing treatment: Submit clinical records that include the recent behavioral re-assessment, treatment plan update - including location of services and current Individualized Education Plan.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
97154	Group adaptive behavior treatment by protocol, administered by technician under the direction of a physician or other qualified health care professional, face-to-face with two or more patients, each 15 minutes	Prior Authorization Required	Medical Necessity Review Required	For initial treatment: Submit clinical records including verification that autism spectrum disorder diagnosis was made by appropriate diagnosing provider, copy of functional behavioral assessment, treatment plan - including location of services and current Individualized Education Plan. For ongoing treatment: Submit clinical records that include the recent behavioral re-assessment, treatment plan update - including location of services and current Individualized Education Plan.
97155	Adaptive behavior treatment with protocol modification, administered by physician or other qualified health care professional, which may include simultaneous direction of technician, face-to-face with one patient, each 15 minutes	Prior Authorization Required	Medical Necessity Review Required	For initial treatment: Submit clinical records including verification that autism spectrum disorder diagnosis was made by appropriate diagnosing provider, copy of functional behavioral assessment, treatment plan - including location of services and current Individualized Education Plan. For ongoing treatment: Submit clinical records that include the recent behavioral re-assessment, treatment plan update - including location of services and current Individualized Education Plan.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
97156	Family adaptive behavior treatment guidance, administered by physician or other qualified health care professional (with or without the patient present), face-to-face with guardian(s)/caregiver(s), each 15 minutes	Prior Authorization Required	Medical Necessity Review Required	For initial treatment: Submit clinical records including verification that autism spectrum disorder diagnosis was made by appropriate diagnosing provider, copy of functional behavioral assessment, treatment plan - including location of services and current Individualized Education Plan. For ongoing treatment: Submit clinical records that include the recent behavioral re-assessment, treatment plan update - including location of services and current Individualized Education Plan.
97158	Group adaptive behavior treatment with protocol modification, administered by physician or other qualified health care professional, face-to-face with multiple patients, each 15 minutes	Prior Authorization Required	Medical Necessity Review Required	For initial treatment: Submit clinical records including verification that autism spectrum disorder diagnosis was made by appropriate diagnosing provider, copy of functional behavioral assessment, treatment plan - including location of services and current Individualized Education Plan. For ongoing treatment: Submit clinical records that include the recent behavioral re-assessment, treatment plan update - including location of services and current Individualized Education Plan.
97169	Athletic training evaluation, low complexity	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
97170	Athletic training evaluation, moderate complexity	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
97171	Athletic training evaluation, high complexity	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
97172	Re-evaluation of athletic training	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.

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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	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
97550	Caregiver training in strategies and techniques to facilitate the patient's functional performance in the home or community (eg, activities of daily living [ADLs], instrumental ADLs [iADLs], transfers, mobility, communication, swallowing, feeding, problem solving, safety practices) (without the patient present), face to face; initial 30 minutes	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
97551	Caregiver training in strategies and techniques to facilitate the patient's functional performance in the home or community (eg, activities of daily living [ADLs], instrumental ADLs [iADLs], transfers, mobility, communication, swallowing, feeding, problem solving, safety practices) (without the patient present), face to face; each additional 15 minutes (List separately in addition to code for primary service)	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
97552	Group caregiver training in strategies and techniques to facilitate the patient's functional performance in the home or community (eg, activities of daily living [ADLs], instrumental ADLs [iADLs], transfers, mobility, communication, swallowing, feeding, problem solving, safety practices) (without the patient present), face to face with multiple sets of caregivers	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.

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97799	Unlisted physical medicine/rehabilitation service or procedure	Advance Benefit Determination (ABD) recommended	Medical Necessity	If provider is Rehab Without Walls, there are no FEP benefits for which this provider is contracted. For all other providers, submit documentation to describe the services. Specify procedure performed and treatment plan.
98960	Education and training for patient self-management by a nonphysician qualified health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family) each 30 minutes; individual patient	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
98961	Education and training for patient self-management by a nonphysician qualified health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family) each 30 minutes; 2-4 patients	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
98962	Education and training for patient self-management by a nonphysician qualified health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family) each 30 minutes; 5-8 patients	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
98970	Nonphysician qualified health care professional online digital assessment and management, for an established patient, for up to 7 days, cumulative time during the 7 days; 5-10 minutes	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.

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98971	Nonphysician qualified health care professional online digital assessment and management, for an established patient, for up to 7 days, cumulative time during the 7 days; 11-20 minutes	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
98972	Nonphysician qualified health care professional online digital assessment and management, for an established patient, for up to 7 days, cumulative time during the 7 days; 21 or more minutes	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
98975	Remote therapeutic monitoring (eg, therapy adherence, therapy response, digital therapeutic intervention); initial set-up and patient education on use of equipment	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
98976	Remote therapeutic monitoring (eg, therapy adherence, therapy response, digital therapeutic intervention); device(s) supply for data access or data transmissions to support monitoring of respiratory system, each 30 days	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
98977	Remote therapeutic monitoring (eg, therapy adherence, therapy response, digital therapeutic intervention); device(s) supply for data access or data transmissions to support monitoring of musculoskeletal system, each 30 day	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
98978	Remote therapeutic monitoring (eg, therapy adherence, therapy response); device(s) supply with scheduled (eg, daily) recording(s) and/or programmed alert(s) transmission to monitor cognitive behavioral therapy, each 30 days	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
98980	Remote therapeutic monitoring treatment management services, physician or other qualified health care professional time in a calendar month requiring at least one interactive communication with the patient or caregiver during the calendar month; first 20 minutes	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
98981	Remote therapeutic monitoring treatment management services, physician or other qualified health care professional time in a calendar month requiring at least one interactive communication with the patient or caregiver during the calendar month; each additional 20 minutes (List separately in addition to code for primary procedure)	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
99026	Hospital mandated on call service; in-hospital, each hour	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
99027	Hospital mandated on call service; out-of-hospital, each hour	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
99053	Service(s) provided between 10:00 PM and 8:00 AM at 24-hour facility, in addition to basic service	Non-covered Service	Not Covered	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	Not Covered	Considered non-covered unless member's contract indicates coverage.
99058	Service(s) provided on an emergency basis in the office, which disrupts other scheduled office services, in addition to basic service	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
99060	Service(s) provided on an emergency basis, out of the office, which disrupts other scheduled office services, in addition to basic service	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
99071	Educational supplies, such as books, tapes, and pamphlets, for the patient's education at cost to physician or other qualified health care professional	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
99075	Medical testimony	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
99078	Physician or other qualified health care professional qualified by education, training, licensure/regulation (when applicable) educational services rendered to patients in a group setting (eg, prenatal, obesity, or diabetic instructions)	Non-covered Service	Not Covered	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	Not Covered	Considered non-covered unless member's contract indicates coverage.
99082	Unusual travel (eg, transportation and escort of patient)	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
99091	Collection and interpretation of physiologic data (eg, ecg, blood pressure, glucose monitoring) digitally stored and/or transmitted by the patient and/or caregiver to the physician or other qualified health care professional, qualified by education, training, licensure/regulation (when applicable) requiring a minimum of 30 minutes of time, each 30 days	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
99183	Physician attendance and supervision of hyperbaric oxygen therapy, per session	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, documentation of medical necessity, and treatment plan
99199	Unlisted special service or report	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical and description of service(s) provided

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
99360	Standby service, requiring prolonged attendance, each 30 minutes (eg, operative standby, standby for frozen section, for cesarean/high risk delivery, for monitoring EEG)	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history and physical, documentation of medical necessity.
99367	Medical team conference with interdisciplinary team of health care professionals, patient and/or family not present, 30 minutes or more; participation by physician	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
99368	Medical team conference with interdisciplinary team of health care professionals, patient and/or family not present, 30 minutes or more; participation by nonphysician qualified health care professional	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
99421	Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 5-10 minutes	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
99422	Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 11-20 minutes	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
99423	Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 21 or more minutes	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
99429	Unlisted preventive medicine svc	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.

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99437	Chronic care management services with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, chronic conditions that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, comprehensive care plan established, implemented, revised, or monitored; each additional 30 minutes by a physician or other qualified health care professional, per calendar month (List separately in addition to code for primary procedure)	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
99439	Chronic care management services with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, chronic conditions that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, comprehensive care plan established, implemented, revised, or monitored; each additional 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month (List separately in addition to code for primary procedure)	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
99446	Interprofessional telephone/Internet/electronic health record assessment and management service provided by a consultative physician or other qualified health care professional, including a verbal and written report to the patient's treating/requesting physician or other qualified health care professional; 5-10 minutes of medical consultative discussion and review	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
99447	Interprofessional telephone/Internet/electronic health record assessment and management service provided by a consultative physician or other qualified health care professional, including a verbal and written report to the patient's treating/requesting physician or other qualified health care professional; 11-20 minutes of medical consultative discussion and review	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
99448	Interprofessional telephone/Internet/electronic health record assessment and management service provided by a consultative physician or other qualified health care professional, including a verbal and written report to the patient's treating/requesting physician or other qualified health care professional; 21-30 minutes of medical consultative discussion and review	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.

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99449	Interprofessional telephone/Internet/electronic health record assessment and management service provided by a consultative physician or other qualified health care professional, including a verbal and written report to the patient's treating/requesting physician or other qualified health care professional; 31 minutes or more of medical consultative discussion and review	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
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	Not Covered	Considered non-covered unless member's contract indicates coverage.
99451	Interprofessional telephone/Internet/electronic health record assessment and management service provided by a consultative physician or other qualified health care professional, including a written report to the patient's treating/requesting physician or other qualified health care professional, 5 minutes or more of medical consultative time	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
99452	Interprofessional telephone/Internet/electronic health record referral service(s) provided by a treating/requesting physician or other qualified health care professional, 30 minutes	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.

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99453	Remote monitoring of physiologic parameter(s) (eg, weight, blood pressure, pulse oximetry, respiratory flow rate), initial; set-up and patient education on use of equipment	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
99454	Remote monitoring of physiologic parameter(s) (eg, weight, blood pressure, pulse oximetry, respiratory flow rate), initial; device(s) supply with daily recording(s) or programmed alert(s) transmission, each 30 days	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
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	Not Covered	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	Not Covered	Considered non-covered unless member's contract indicates coverage.

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99457	Remote physiologic monitoring treatment management services, 20 minutes or more of clinical staff/physician/other qualified health care professional time in a calendar month requiring interactive communication with the patient/caregiver during the month	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
99458	Remote physiologic monitoring treatment management services, clinical staff/physician/other qualified health care professional time in a calendar month requiring interactive communication with the patient/caregiver during the month; each additional 20 minutes (List separately in addition to code for primary procedure)	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
99473	Self-measured blood pressure using a device validated for clinical accuracy; patient education/training and device calibration	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
99474	Self-measured blood pressure using a device validated for clinical accuracy; separate self-measurements of two readings one minute apart, twice daily over a 30-day period (minimum of 12 readings), collection of data reported by the patient and/or caregiver to the physician or other qualified health care professional, with report of average systolic and diastolic pressures and subsequent communication of a treatment plan to the patient	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.

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Code List

Code	Description	Plan Review Requirement	Reviewed For	Records Request
99487	Complex chronic care management services with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, chronic conditions that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, comprehensive care plan established, implemented, revised, or monitored, moderate or high complexity medical decision making; first 60 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
99489	Complex chronic care management services with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, chronic conditions that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, comprehensive care plan established, implemented, revised, or monitored, moderate or high complexity medical decision making; each additional 30 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month (List separately in addition to code for primary procedure)	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.

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99490	Chronic care management services with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, chronic conditions that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, comprehensive care plan established, implemented, revised, or monitored; first 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
99491	Chronic care management services with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, chronic conditions that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, comprehensive care plan established, implemented, revised, or monitored; first 30 minutes provided personally by a physician or other qualified health care professional, per calendar month	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
99497	Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional; first 30 minutes, face-to-face with the patient, family member(s), and/or surrogate	Prior Authorization Required	Medical Necessity	Submit history and physical and documentation of treatment /care plan

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99498	Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional; each additional 30 minutes (List separately in addition to code for primary procedure)	Prior Authorization Required	Medical Necessity	Submit history and physical and documentation of treatment /care plan
99499	Unlisted evaluation & management service	Medical Necessity review will be performed upon claims submission	Medical Necessity	History and physical and description of service(s) provided
99509	Home visit for assistance with activities of daily living and personal care	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
99600	Unlisted home visit service or procedure	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit documented to describe the services. Include the chart notes for each home visit, including documentation of home bound status and treatment plan
A0021	Ambulance Service, outside state per mile, transport	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
A0080	Nonemergency transportation, per mile - vehicle provided by volunteer (individual or organization), with no vested interest	Non-covered Service	Not Covered	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	Not Covered	Considered non-covered unless member's contract indicates coverage.
A0100	Nonemergency transportation; taxi	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
A0110	Nonemergency transportation and bus, intra- or interstate carrier	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
A0120	Nonemergency transportation: mini-bus, mountain area transports, or other transportation systems	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
A0130	Nonemergency transportation: wheelchair van	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.

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A0140	Nonemergency transportation and air travel (private or commercial) intra- or interstate	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
A0160	Nonemergency transportation: per mile - caseworker or social worker	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
A0170	Transportation ancillary: parking fees, tolls, other	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
A0180	Nonemergency transportation: ancillary: lodging, recipient	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
A0190	Nonemergency transportation: ancillary: meals, recipient	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
A0200	Nonemergency transportation: ancillary: lodging, escort	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
A0210	Nonemergency transportation: ancillary: meals, escort	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
A0420	AMB WAITING TIME 1/2 HR INCREMENTS	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
A0424	Extra ambulance attendant, ground (ALS or BLS) or air (fixed or rotary winged); (requires medical review)	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit progress notes for the last 24 hours prior to transport, and physician order, including medical records supporting the rationale for transport
A0425	Ground mileage, per statute mile	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit progress notes for the last 24 hours prior to transport, and physician order, including medical records supporting the rationale for transport
A0426	Ambulance service, advanced life support, nonemergency transport, level 1 (ALS 1)	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit progress notes for the last 24 hours prior to transport, and physician order, including medical records supporting the rationale for transport
A0427	Ambulance service, advanced life support, emergency transport, level 1 (ALS 1 - emergency)	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit progress notes for the last 24 hours prior to transport, and physician order, including medical records supporting the rationale for transport
A0428	Ambulance service, basic life support, nonemergency transport, (BLS)	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit progress notes for the last 24 hours prior to transport, and physician order, including medical records supporting the rationale for transport

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
A0430	Ambulance service, conventional air services, transport, one way (fixed wing)	Prior Authorization Required	Medical Necessity Review Required	Submit progress notes for last 24 hours prior to transport, physician order including medical records supporting rationale for transport. For transport beyond the nearest facility adequately equipped to treat the memberâ€™s condition, provide supporting documentation to show why nearest facilities are not available.
A0431	Ambulance service, conventional air services, transport, one way (rotary wing)	Prior Authorization Required	Medical Necessity Review Required	Submit progress notes for last 24 hours prior to transport, physician order including medical records supporting rationale for transport. For transport beyond the nearest facility adequately equipped to treat the memberâ€™s condition, provide supporting documentation to show why nearest facilities are not available.
A0434	Specialty care transport (SCT)	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit progress notes for the last 24 hours prior to transport, with physician order including medical records supporting rationale for transport. Prior authorization is required for non-emergent air transport.
A0435	Fixed wing air mileage, per statute mile	Prior Authorization Required	Medical Necessity Review Required	Submit progress notes for last 24 hours prior to transport, physician order including medical records supporting rationale for transport. For transport beyond the nearest facility adequately equipped to treat the memberâ€™s condition, provide supporting documentation to show why nearest facilities are not available.

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A0436	Rotary wing air mileage, per statute mile	Prior Authorization Required	Medical Necessity Review Required	Submit progress notes for last 24 hours prior to transport, physician order including medical records supporting rationale for transport. For transport beyond the nearest facility adequately equipped to treat the memberâ€™s condition, provide supporting documentation to show why nearest facilities are not available.
A0888	Noncovered ambulance mileage, per mile (e.g., for miles traveled beyond closest appropriate facility)	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
A0999	Unlisted ambulance service	Advance Benefit Determination (ABD) recommended	Medical Necessity	Allow per IHM when billed charge is less than $300. For billed charges greater than $300, submit the description of item provided, and letter of medical necessity including member's current medical condition
A2001	InnovaMatrix AC, per square centimeter (add-on, list separately in addition to primary procedure)	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history and physical, documentation of medical necessity.
A2002	Mirragen Advanced Wound Matrix, per square centimeter (add-on, list separately in addition to primary procedure)	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history and physical, documentation of medical necessity.
A2004	XCelliStem, per square centimeter (add-on, list separately in addition to primary procedure)	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history and physical, documentation of medical necessity.
A2005	Microlyte Matrix, per square centimeter (add-on, list separately in addition to primary procedure)	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history and physical, documentation of medical necessity.
A2006	NovoSorb SynPath dermal matrix, per square centimeter (add-on, list separately in addition to primary procedure)	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history and physical, documentation of medical necessity.

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Code List

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A2007	Restrata, per square centimeter (add-on, list separately in addition to primary procedure)	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history and physical, documentation of medical necessity.
A2008	TheraGenesis, per square centimeter (add-on, list separately in addition to primary procedure)	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history and physical, documentation of medical necessity.
A2009	Symphony, per square centimeter (add-on, list separately in addition to primary procedure)	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history and physical, documentation of medical necessity.
A2010	Apis, per square centimeter (add-on, list separately in addition to primary procedure)	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history and physical, documentation of medical necessity.
A2011	Supra SDRM, per square centimeter (add-on, list separately in addition to primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	Submit history and physical, documentation of medical necessity.
A2012	Suprathel, per square centimeter (add-on, list separately in addition to primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	Submit history and physical, documentation of medical necessity.
A2013	InnovaMatrix FS, per square centimeter (add-on, list separately in addition to primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	Submit history and physical, documentation of medical necessity.
A2014	Omeza Collagen Matrix or Omeza Complete Matrix, per 100 mg	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	Submit history and physical, documentation of medical necessity.
A2015	Phoenix Wound Matrix, per square centimeter (add-on, list separately in addition to primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	Submit history and physical, documentation of medical necessity.
A2016	PermeaDerm B, per square centimeter (add-on, list separately in addition to primary procedure)	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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A2017	PermeaDerm Glove, each	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	Submit history and physical, documentation of medical necessity.
A2018	PermeaDerm C, per square centimeter (add-on, list separately in addition to primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	Submit history and physical, documentation of medical necessity.
A2019	Kerecis Omega3 Marigen Shield, per square centimeter (add-on, list separately in addition to primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Investigative	Submit history and physical, documentation of medical necessity.
A2020	Ac5 Advanced Wound System (AC5)	Medical necessity review will be performed upon claims submission with supporting documentation	Investigative	Submit history and physical, documentation of medical necessity.
A2021	Neomatrix, per square centimeter (add-on, list separately in addition to primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Investigative	Submit history and physical, documentation of medical necessity.
A2022	Innovaburn or Innovamatrix XL, per square centimeter (add-on, list separately in addition to primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	Submit history and physical, documentation of medical necessity.
A2023	Innovamatrix PD, 1 mg.	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	Submit history and physical, documentation of medical necessity.
A2024	Resolve matrix or Xenopatch, per square centimeter (add-on, list separately in addition to primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	Submit history and physical, documentation of medical necessity.
A2025	Miro3D, per cubic centimeter (add-on, list separately in addition to primary procedure)	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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A2026	Restrata minimatrix, 5 mg	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	Submit history and physical, documentation of medical necessity.
A2030	Miro3d fibers, per milligram	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	Submit history and physical, documentation of medical necessity.
A2031	Mirodry wound matrix, per square centimeter (add-on, list separately in addition to primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	Submit history and physical, documentation of medical necessity.
A2032	Myriad matrix, per square centimeter (add-on, list separately in addition to primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	Submit history and physical, documentation of medical necessity.
A2033	Myriad morcells, 4 milligrams	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	Submit history and physical, documentation of medical necessity.
A2034	Foundation drs solo, per square centimeter (add-on, list separately in addition to primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	Submit history and physical, documentation of medical necessity.
A2035	Corplex p or theracor p or allacor p, per milligram	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	Submit history and physical, documentation of medical necessity.
A4100	Skin substitute, FDA cleared as a device, not otherwise specified (add-on, list separately in addition to primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	Submit history and physical, documentation of medical necessity.
A4265	Paraffin, per pound	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
A4267	Contraceptive supply, condom, male, each	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.

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A4268	Contraceptive supply, condom, female, each	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
A4269	Contraceptive supply, spermicide (e.g., foam, gel), each	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
A4281	Tubing for breast pump, replacement	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
A4282	Adapter for breast pump, replacement	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
A4283	Cap for breast pump bottle, replacement	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
A4284	Breast shield and splash protector for use with breast	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
A4285	Polycarbonate bottle for use with breast pump,	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
A4286	Locking ring for breast pump, replacement	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
A4287	Disposable collection and storage bag for breast milk, any size, any type, each	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
A4290	Sacral nerve stimulation test lead, each	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, and procedure report. medical necessity review will be performed upon claims submission with supporting documentation
A4335	Incontinence supply; miscellaneous	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
A4336	Incontinence supply, urethral INSERT, any type, each	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
A4337	Incontinence supply, rectal INSERT, any type, each	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
A4458	Enema bag with tubing, reusable	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
A4520	Incontinence garment, any type, (e.g., brief, diaper), each	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
A4540	Distal transcutaneous electrical nerve stimulator, stimulates peripheral nerves of the upper arm	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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A4541	Monthly supplies for use of device coded at E0733	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	Submit history and physical, documentation of medical necessity.
A4542	Supplies and accessories for external upper limb tremor stimulator of the peripheral nerves of the wrist	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	Submit history and physical, documentation of medical necessity.
A4553	Non-disposable underpads, all sizes	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
A4554	Disposable underpads, all sizes	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
A4555	Electrode/transducer for use with electrical stimulation device used for cancer treatment, replacement only	Advance Benefit Determination (ABD) recommended	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	Not Covered	Considered non-covered unless member's contract indicates coverage.
A4575	Topical hyperbaric oxygen chamber, disposable	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
A4596	Cranial electrotherapy stimulation (CES) system supplies and accessories, per month	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	Submit history and physical, documentation of medical necessity.
A4634	Replacement bulb for therapeutic light box, tabletop model	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
A4639	Replacement pad for infrared heating pad system, each	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
A4660	Sphygmomanometer/blood pressure apparatus with cuff and stethoscope	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
A4663	Blood pressure cuff only	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
A4670	Automatic blood pressure monitor	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
A4890	Contracts, repair and maintenance for home dialysis	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.

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A4931	Oral thermometer, reusable, any type, each	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
A4932	Rectal thermometer, reusable, any type, each	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
A5500	For diabetics only, fitting (including follow-up), custom	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
A5501	For diabetics only, fitting (including follow-up), custom	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
A5503	For diabetics only, modification (including fitting) of off-the shelf depth-inlay shoe or custom molded shoe with roller or rigid rocker bottom, per shoe	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
A5504	For diabetics only, modification (including fitting) of off-the shelf depth-inlay shoe or custom molded shoe with wedge(s), per shoe	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
A5505	For diabetics only, modification (including fitting) of off-the shelf depth-inlay shoe or custom molded shoe with metatarsal bar, per shoe	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
A5506	For diabetics only, modification (including fitting) of off-the shelf depth-inlay shoe or custom-molded shoe with off-set heel(s), per shoe	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
A5507	For diabetics only, not otherwise specified modification	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
A5508	For diabetics only, deluxe feature of off-the-shelf depth-inlay shoe or custom molded shoe, per shoe	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
A6590	External urinary catheters; disposable, with wicking	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
A7047	Oral interface used with respiratory suction pump, each	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history and physical, documentation of medical necessity.
A9150	Nonprescription drugs	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
A9152	Single vitamin/mineral/trace element, oral, per dose, not otherwise specified	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.

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A9153	Multiple vitamins, with or without minerals and trace elements, oral, per dose, not otherwise specified	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
A9180	Pediculosis (lice infestation) treatment, topical, for administration by patient/caretaker	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
A9270	Noncovered item or service	Non-covered Service	Not Covered	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	Not Covered	Considered non-covered unless member's contract indicates coverage.
A9275	Home glucose disposable monitor, includes test strips	Non-covered Service	Not Covered	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	Advance Benefit Determination (ABD) recommended	Medical Necessity	Allow per IHM when billed charge is less than $100. For billed charges greater than $100, submit the description of the item provided, and letter of medical necessity, including member's current medical condition
A9280	Alert or alarm device, not otherwise classified	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
A9281	Reaching/grabbing device, any type, any length, each	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
A9282	Wig, any type, each	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
A9286	Hygienic item or device, disposable or non-disposable, any type, each	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
A9291	Prescription digital cognitive and/or behavioral therapy, FDA cleared, per course of treatment	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
A9300	Exercise equipment	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
A9513	Lutetium lu 177, dotatate, therapeutic, 1 millicurie	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, and documentation of medical necessity. medical necessity review will be performed upon claims submission with supporting documentation

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A9542	Indium In-111 ibritumomab tiuxetan, diagnostic, per study dose, up to 5 millicuries	Advance Benefit Determination (ABD) recommended	Medical Necessity	History of physical and plan of care, including procedure report
A9543	Yttrium Y-90 ibritumomab tiuxetan, therapeutic, per treatment dose, up to 40 millicuries	Advance Benefit Determination (ABD) recommended	Medical Necessity	History of physical and plan of care, including procedure report. medical necessity review will be performed upon claims submission with supporting documentation
A9582	Iodine I-123 iobenguane, diagnostic, per study dose, up to 15 millicuries	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history and physical, documentation of medical necessity and procedure report.
A9590	Iodine i-131, Iobenguane, 1 millicurie	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, and documentation of medical necessity. medical necessity review will be performed upon claims submission with supporting documentation
A9591	Fluoroestradiol F-18, diagnostic, 1 mCi	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit procedure/testing report
A9595	PIFLUFOLASTAT F 18 (PYLARIFY), DIAGNOSTIC, 1 MILLICURIE	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit procedure/testing report
A9607	Lutetium Lu 177 vipivotide tetraxetan, therapeutic, 1 mCi	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	Submit history and physical, documentation of medical necessity.
A9699	Radiopharmaceutical, therapeutic, not otherwise classified	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history and physical, documentation of medical necessity.
A9900	Miscellaneous DME supply, accessory, and/or service component of another HCPCS code	Advance Benefit Determination (ABD) recommended	Medical Necessity	Allow per IHM when billed charge is less than $100. For billed charges greater than $100, submit the description of the item provided, and letter of medical necessity, including member's current medical condition
A9901	DME delivery, set up, and/or dispensing service component of another HCPCS code	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.

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A9999	Miscellaneous DME supply or accessory, not otherwise specified	Advance Benefit Determination (ABD) recommended	Medical Necessity	Allow per IHM when billed charge is less than $100. For billed charges greater than $100, submit the description of the item provided, and letter of medical necessity, including member's current medical condition
B4100	Food thickener, administered orally, per oz	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
B4102	Enteral formula, for adults, used to replace fluids and electrolytes (e.g., clear liquids), 500 ml = 1 unit	Medical necessity review will be performed upon claims submission with supporting documentation	Potential Contract Exclusion	Medical food/formula administered by catheter or nasogastric tube is allowed under medical benefits; if enteral feeding is done via tube, load and allow for 1 year.Note: Medical food/formula taken orally is not covered under medical benefits (refer member/provider to Caremark for food/formula taken orally).
B4103	Enteral formula, for pediatrics, used to replace fluids and electrolytes (e.g., clear liquids), 500 ml = 1 unit	Medical necessity review will be performed upon claims submission with supporting documentation	Potential Contract Exclusion	Medical food/formula administered by catheter or nasogastric tube is allowed under medical benefits; if enteral feeding is done via tube, load and allow for 1 year.Note: Medical food/formula taken orally is not covered under medical benefits (refer member/provider to Caremark for food/formula taken orally).
B4104	Additive for enteral formula (e.g., fiber)	Medical necessity review will be performed upon claims submission with supporting documentation	Potential Contract Exclusion	Medical food/formula administered by catheter or nasogastric tube is allowed under medical benefits; if enteral feeding is done via tube, load and allow for 1 year.Note: Medical food/formula taken orally is not covered under medical benefits (refer member/provider to Caremark for food/formula taken orally).

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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	Medical necessity review will be performed upon claims submission with supporting documentation	Potential Contract Exclusion	Medical food/formula administered by catheter or nasogastric tube is allowed under medical benefits; if enteral feeding is done via tube, load and allow for 1 year.Note: Medical food/formula taken orally is not covered under medical benefits (refer member/provider to Caremark for food/formula taken orally).
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	Medical necessity review will be performed upon claims submission with supporting documentation	Potential Contract Exclusion	Medical food/formula administered by catheter or nasogastric tube is allowed under medical benefits; if enteral feeding is done via tube, load and allow for 1 year.Note: Medical food/formula taken orally is not covered under medical benefits (refer member/provider to Caremark for food/formula taken orally).
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	Medical necessity review will be performed upon claims submission with supporting documentation	Potential Contract Exclusion	Medical food/formula administered by catheter or nasogastric tube is allowed under medical benefits; if enteral feeding is done via tube, load and allow for 1 year.Note: Medical food/formula taken orally is not covered under medical benefits (refer member/provider to Caremark for food/formula taken orally).
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	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	Medical food/formula administered by catheter or nasogastric tube is allowed under medical benefits; if enteral feeding is done via tube, load and allow for 1 year.Note: Medical food/formula taken orally is not covered under medical benefits (refer member/provider to Caremark for food/formula taken orally).

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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	Medical necessity review will be performed upon claims submission with supporting documentation	Potential Contract Exclusion	Medical food/formula administered by catheter or nasogastric tube is allowed under medical benefits; if enteral feeding is done via tube, load and allow for 1 year.Note: Medical food/formula taken orally is not covered under medical benefits (refer member/provider to Caremark for food/formula taken orally).
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	Medical necessity review will be performed upon claims submission with supporting documentation	Potential Contract Exclusion	Medical food/formula administered by catheter or nasogastric tube is allowed under medical benefits; if enteral feeding is done via tube, load and allow for 1 year.Note: Medical food/formula taken orally is not covered under medical benefits (refer member/provider to Caremark for food/formula taken orally).
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	Medical necessity review will be performed upon claims submission with supporting documentation	Potential Contract Exclusion	Medical food/formula administered by catheter or nasogastric tube is allowed under medical benefits; if enteral feeding is done via tube, load and allow for 1 year.Note: Medical food/formula taken orally is not covered under medical benefits (refer member/provider to Caremark for food/formula taken orally).
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	Medical necessity review will be performed upon claims submission with supporting documentation	Potential Contract Exclusion	Medical food/formula administered by catheter or nasogastric tube is allowed under medical benefits; if enteral feeding is done via tube, load and allow for 1 year.Note: Medical food/formula taken orally is not covered under medical benefits (refer member/provider to Caremark for food/formula taken orally).

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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	Medical necessity review will be performed upon claims submission with supporting documentation	Potential Contract Exclusion	Medical food/formula administered by catheter or nasogastric tube is allowed under medical benefits; if enteral feeding is done via tube, load and allow for 1 year.Note: Medical food/formula taken orally is not covered under medical benefits (refer member/provider to Caremark for food/formula taken orally).
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	Medical necessity review will be performed upon claims submission with supporting documentation	Potential Contract Exclusion	Medical food/formula administered by catheter or nasogastric tube is allowed under medical benefits; if enteral feeding is done via tube, load and allow for 1 year.Note: Medical food/formula taken orally is not covered under medical benefits (refer member/provider to Caremark for food/formula taken orally).
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	Medical necessity review will be performed upon claims submission with supporting documentation	Potential Contract Exclusion	Medical food/formula administered by catheter or nasogastric tube is allowed under medical benefits; if enteral feeding is done via tube, load and allow for 1 year.Note: Medical food/formula taken orally is not covered under medical benefits (refer member/provider to Caremark for food/formula taken orally).
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	Medical necessity review will be performed upon claims submission with supporting documentation	Potential Contract Exclusion	Medical food/formula administered by catheter or nasogastric tube is allowed under medical benefits; if enteral feeding is done via tube, load and allow for 1 year.Note: Medical food/formula taken orally is not covered under medical benefits (refer member/provider to Caremark for food/formula taken orally).

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B9998	NOC for enteral supplies	Advance Benefit Determination (ABD) recommended	Medical Necessity	If enteral therapy has been allowed, then allow per IHM when billed charge is less than $300. For billed charges greater than $300, submit the description of item provided, letter of medical necessity including current medical condition and manufacturer invoice.
B9999	NOC for parenteral supplies	Advance Benefit Determination (ABD) recommended	Medical Necessity	Allow per IHM when billed charge is less than $300. For billed charges greater than $300, submit the description of item provided, and letter of medical necessity including member's current medical condition
C1726	Catheter, balloon dilatation, nonvascular	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit procedure/testing report
C1734	Orthopedic/device/drug matrix for opposing bone-to-bone or soft tissue-to bone (implantable)	Advance Benefit Determination (ABD) recommended	Investigative	Submit procedure/testing report
C1735	Catheter(s), intravascular for renal denervation, radiofrequency, including all single use system components	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	Submit history and physical, documentation of medical necessity.
C1764	Event recorder, cardiac (implantable)	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history and physical and documentation of medical necessity
C1813	Prosthesis, penile, inflatable	Prior Authorization Required	Gender Affirming Surgery	For gender affirming surgery: Submit history and physical, chart notes from the session(s) in which the diagnosis of gender dysphoria was determined, documentation of continuous hormone therapy, and written psychological assessment from a qualified mental health professional. For non-gender affirming surgery: Medical necessity review will be performed upon claims submission with supporting documentation.

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Code List

Code	Description	Plan Review Requirement	Reviewed For	Records Request
C1818	Integrated keratoprosthesis	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit letter of medical necessity supporting the need for prosthesis
C1821	Interspinous process distraction device (implantable)	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history,physical and operative report
C1825	Generator, neurostimulator (implantable), nonrechargeable with carotid sinus baroreceptor stimulation lead(s)	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history and physical, documentation of medical necessity.
C1831	Interbody cage, anterior, lateral or posterior, personalized (implantable)	Prior Authorization Required	Medical Necessity	History and physical, pre-op evaluations, imaging reports, conservative measures and response, operative/procedure report, anesthesia report, and documentation of medical necessity
C1832	Autograft suspension, including cell processing and application, and all system components	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history and physical, documentation of medical necessity.
C1833	Monitor, cardiac, including intracardiac lead and all system components (implantable)	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history and physical, documentation of medical necessity.
C1840	Lens, intraocular (telescopic)	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
C1878	Material for vocal cord medialization, synthetic (implantable)	Advance Benefit Determination (ABD) recommended	Potential Contract Exclusion	Submit history and physical, documentation of medical necessity.
C1889	Implantable/ INSERTable device, not otherwise classified	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history and physical and operative/procedure report, as well as documentation to describe services.
C2614	Probe, percutaneous lumbar discectomy	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history,physical and operative report

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C2622	Prosthesis, penile, noninflatable	Prior Authorization Required	Gender Affirming Surgery	For gender affirming surgery: Submit history and physical, chart notes from the session(s) in which the diagnosis of gender dysphoria was determined, documentation of continuous hormone therapy, and written psychological assessment from a qualified mental health professional. For non-gender affirming surgery: Medical necessity review will be performed upon claims submission with supporting documentation.
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	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, pre-op evaluations, imaging reports, conservative measures and response, operative/procedure report, anesthesia report, and documentation of medical necessity
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	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, pre-op evaluations, imaging reports, conservative measures and response, operative/procedure report, anesthesia report, and documentation of medical necessity

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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	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, pre-op evaluations, imaging reports, conservative measures and response, operative/procedure report, anesthesia report, and documentation of medical necessity
C8903	Magnetic resonance imaging with contrast, breast; unilateral	Prior Authorization Required	Medical Necessity	Submit history and physical and documentation of medical necessity, and procedure/imaging report
C8905	Magnetic resonance imaging without contrast followed by with contrast, breast; unilateral	Prior Authorization Required	Medical Necessity	Submit history and physical and documentation of medical necessity, and procedure/imaging report
C8906	Magnetic resonance imaging with contrast, breast; bilateral	Prior Authorization Required	Medical Necessity	Submit history and physical and documentation of medical necessity, and procedure/imaging report
C8908	Magnetic resonance imaging without contrast followed by with contrast, breast; bilateral	Prior Authorization Required	Medical Necessity	Submit history and physical and documentation of medical necessity, and procedure/imaging report
C9047	Injection, caplacizumab-yhdp, 1 mg	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, and documentation of medical necessity. medical necessity review will be performed upon claims submission with supporting documentation
C9101	Injection, oliceridine, 0.1 mg	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	Submit history and physical, documentation of medical necessity.
C9257	Injection, bevacizumab, 0.25 mg	Prior Authorization Required	Medical Necessity	History and physical, and clinical notes of condition being treated, including documentation of previous therapies tried and failed, and proposed treatment plan

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
C9354	Acellular pericardial tissue matrix of nonhuman origin (Veritas), per sq cm	Advance Benefit Determination (ABD) recommended	Investigative	History and physical, documentation for medical necessity and procedure report
C9356	Tendon, porous matrix of cross-linked collagen and glycosaminoglycan matrix (TenoGlide Tendon Protector Sheet), per sq cm	Advance Benefit Determination (ABD) recommended	Investigative	History and physical, documentation for medical necessity and procedure report
C9358	Dermal substitute, native, nondenatured collagen, fetal bovine origin (SurgiMend Collagen Matrix), per 0.5 sq cm	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history and physical, documentation of medical necessity.
C9359	Porous purified collagen matrix bone void filler (Integra Mozaik Osteoconductive Scaffold Putty, Integra OS Osteoconductive Scaffold Putty), per 0.5 cc	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history and physical, documentation of medical necessity.
C9360	Dermal substitute, native, nondenatured collagen, neonatal bovine origin (SurgiMend Collagen Matrix), per 0.5 sq cm	Advance Benefit Determination (ABD) recommended	Investigative	History and physical, documentation for medical necessity and procedure report
C9362	Porous purified collagen matrix bone void filler (Integra Mozaik Osteoconductive Scaffold Strip), per 0.5 cc	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history and physical, documentation of medical necessity.
C9363	Skin substitute (Integra Meshed Bilayer Wound Matrix), per sq cm	Advance Benefit Determination (ABD) recommended	Investigative	History and physical, documentation for medical necessity and procedure report
C9364	Porcine implant, Permacol, per sq cm	Advance Benefit Determination (ABD) recommended	Investigative	History and physical, documentation for medical necessity and procedure report
C9399	Unlisted unclassified drugs or biologicals	Prior Authorization Required	Medical Necessity	History and physical and documentation of medical necessity, including name of drug
C9462	Injection, delafloxacin, 1 mg	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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C9727	Insertion of implants into the soft palate; minimum of three implants	Medical necessity review will be performed upon claims submission with supporting documentation	Investigative	Submit history and physical, documentation of medical necessity.
C9734	Focused ultrasound ablation/therapeutic intervention, other than uterine leiomyomata, with magnetic resonance (MR) guidance	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, imaging studies, procedure report and documentation of medical necessity
C9739	Cystourethroscopy, with insertion of transprostatic implant; one to three implants	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, and documentation of medical necessity, including medical treatments tried
C9740	Cystourethroscopy, with insertion of transprostatic implant; one to three implants	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, and documentation of medical necessity, including medical treatments tried
C9757	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and excision of herniated intervertebral disc, and repair of annular defect with implantation of bone anchored annular closure device, including annular defect measurement, alignment and sizing assessment, and image guidance; 1 interspace, lumbar	Prior Authorization Required	Medical Necessity	History and physical, pre-op evaluations, imaging reports, conservative measures and response, operative/procedure report, anesthesia report, and documentation of medical necessity
C9758	Blind procedure for NYHA Class III/IV heart failure; transcatheter implantation of interatrial shunt including right heart catheterization, transesophageal echocardiography (TEE)/intracardiac echocardiography (ICE), and all imaging with or without guidance (e.g., ultrasound, fluoroscopy), performed in an approved investigational device exemption (IDE) study	Medical necessity review will be performed upon claims submission with supporting documentation	Investigative	Submit history and physical, documentation of medical necessity and procedure report.

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C9760	Nonrandomized, nonblinded procedure for NYHA Class II, III, IV heart failure; transcatheter implantation of interatrial shunt, including right and left heart catheterization, transeptal puncture, transesophageal echocardiography (TEE)/intracardiac echocardiography (ICE), and all imaging with or without guidance (e.g., ultrasound, fluoroscopy), performed in an approved investigational device exemption (IDE) study	Medical necessity review will be performed upon claims submission with supporting documentation	Investigative	Submit history and physical, documentation of medical necessity and procedure report.
C9762	Cardiac magnetic resonance imaging for morphology and function, quantification of segmental dysfunction; with strain imaging	Prior Authorization Required	Medical Necessity	Submit history and physical and documentation of medical necessity, and procedure/imaging report
C9763	Cardiac magnetic resonance imaging for morphology and function, quantification of segmental dysfunction; with stress imaging	Prior Authorization Required	Medical Necessity	Submit history and physical and documentation of medical necessity, and procedure/imaging report
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	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, pre-op evaluations, imaging reports, conservative measures and response, operative/procedure report, anesthesia report, and documentation of medical necessity
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	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, pre-op evaluations, imaging reports, conservative measures and response, operative/procedure report, anesthesia report, and documentation of medical necessity

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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	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, pre-op evaluations, imaging reports, conservative measures and response, operative/procedure report, anesthesia report, and documentation of medical necessity
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	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, pre-op evaluations, imaging reports, conservative measures and response, operative/procedure report, anesthesia report, and documentation of medical necessity
C9772	Revascularization, endovascular, open or percutaneous, tibial/peroneal artery(ies), with intravascular lithotripsy, includes angioplasty within the same vessel(s), when performed	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, pre-op evaluations, imaging reports, conservative measures and response, operative/procedure report, anesthesia report, and documentation of medical necessity
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	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, pre-op evaluations, imaging reports, conservative measures and response, operative/procedure report, anesthesia report, and documentation of medical necessity
C9774	Revascularization, endovascular, open or percutaneous, tibial/peroneal artery(ies); with intravascular lithotripsy and atherectomy, includes angioplasty within the same vessel(s), when performed	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, pre-op evaluations, imaging reports, conservative measures and response, operative/procedure report, anesthesia report, and documentation of medical necessity

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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	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, pre-op evaluations, imaging reports, conservative measures and response, operative/procedure report, anesthesia report, and documentation of medical necessity
C9782	Blinded procedure for New York Heart Association (NYHA) class II or III heart failure, or Canadian Cardiovascular Society (CCS) Class III or IV chronic refractory angina; transcatheter intramyocardial transplantation of autologous bone marrow cells (e.g., mononuclear) or placebo control, autologous bone marrow harvesting and preparation for transplantation, left heart catheterization including ventriculography, all laboratory services, and all imaging with or without guidance (e.g., transthoracic echocardiography, ultrasound, fluoroscopy), performed in an approved Investigational Device Exemption (IDE) study	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
C9783	Blinded procedure for transcatheter implantation of	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
C9784	Gastric restrictive procedure, endoscopic sleeve gastroplasty, with esophagogastroduodenoscopy and intraluminal tube insertion, if performed, including all system and tissue anchoring components	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
C9785	Endoscopic outlet reduction, gastric pouch application, with endoscopy and intraluminal tube insertion, if performed, including all system and tissue anchoring components	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.

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C9791	Magnetic resonance imaging with inhaled hyperpolarized xenon-129 contrast agent, chest, including preparation and administration of agent	Prior Authorization Required	Medical Necessity	Submit history and physical and documentation of medical necessity, and procedure/imaging report
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	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, documentation of infertility, including treatment plan
C9796	Repair of enterocutaneous fistula small intestine or colon (excluding anorectal fistula) with plug (e.g., porcine small intestine submucosa [SIS])	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	Submit history and physical, documentation of medical necessity and procedure report.
C9899	Implanted prosthetic device, payable only for inpatients who do not have inpatient coverage	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	Submit history and physical, documentation of medical necessity.
E0170	Commode chair with integrated seat lift mechanism, electric, any type	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
E0171	Commode chair with integrated seat lift mechanism, nonelectric, any type	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
E0172	Seat lift mechanism placed over or on top of toilet, any type	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
E0193	Powered air flotation bed (low air loss therapy)	Advance Benefit Determination (ABD) recommended	Medical Necessity	Letter of medical necessity containing the following information: Description of member's medical condition requiring use of equipment, including mobility status and anticipated length of time that member will require the equipment. medical necessity review will be performed upon claims submission with supporting documentation

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E0194	Air fluidized bed	Advance Benefit Determination (ABD) recommended	Medical Necessity	Letter of medical necessity containing the following information: Description of member's medical condition requiring use of equipment, including mobility status and anticipated length of time that member will require the equipment. medical necessity review will be performed upon claims submission with supporting documentation
E0200	Heat lamp, without stand (table model), includes bulb, or infrared element	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
E0203	Therapeutic lightbox, minimum 10,000 lux, table top model	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
E0205	Heat lamp, with stand, includes bulb, or infrared element	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
E0210	Electric heat pad, standard	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
E0215	Electric heat pad, moist	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
E0217	Water circulating heat pad with pump	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
E0218	Fluid circulating cold pad with pump, any type	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	Letter of medical necessity
E0221	Infrared heating pad system	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
E0235	Paraffin bath unit, portable (see medical supply code A4265 for paraffin)	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
E0236	Pump for water circulating pad	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	Letter of medical necessity
E0240	Bath/shower chair, with or without wheels, any size	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.

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E0241	Bathtub wall rail, each	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
E0242	Bathtub rail, floor base	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
E0243	Toilet rail, each	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
E0244	Raised toilet seat	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
E0245	Tub stool or bench	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
E0246	Transfer tub rail attachment	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
E0247	Transfer bench for tub or toilet with or without commode opening	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
E0248	Transfer bench, heavy-duty, for tub or toilet with or without commode opening	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
E0249	Pad for water circulating heat unit, for replacement only	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	Letter of medical necessity
E0250	Hospital bed, fixed height, with any type side rails, with mattress	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	Letter of medical necessity containing the following information: Description of member's medical condition requiring use of equipment, including mobility status and anticipated length of time that member will require the equipment (no review needed if rental)
E0251	Hospital bed, fixed height, with any type side rails, without mattress	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	Letter of medical necessity containing the following information: Description of member's medical condition requiring use of equipment, including mobility status and anticipated length of time that member will require the equipment (no review needed if rental)

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E0255	Hospital bed, variable height, hi-lo, with any type side rails, with mattress	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	Letter of medical necessity containing the following information: Description of member's medical condition requiring use of equipment, including mobility status and anticipated length of time that member will require the equipment (no review needed if rental)
E0256	Hospital bed, variable height, hi-lo, with any type side rails, without mattress	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	Letter of medical necessity containing the following information: Description of member's medical condition requiring use of equipment, including mobility status and anticipated length of time that member will require the equipment (no review needed if rental)
E0260	Hospital bed, semi-electric (head and foot adjustment), with any type side rails, with mattress	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	Letter of medical necessity containing the following information: Description of member's medical condition requiring use of equipment, including mobility status and anticipated length of time that member will require the equipment (no review needed if rental)
E0261	Hospital bed, semi-electric (head and foot adjustment), with any type side rails, without mattress	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	Letter of medical necessity containing the following information: Description of member's medical condition requiring use of equipment, including mobility status and anticipated length of time that member will require the equipment (no review needed if rental)
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 equipment needed/required
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 equipment needed/required; no review needed if rental

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E0270	Hospital bed, institutional type includes: oscillating, circulating and Stryker frame, with mattress	Prior Authorization Required	Medical Necessity	Letter of medical necessity, including mobility status and anticipated length of time equipment needed/required; no review needed if rental
E0273	Bed board	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
E0274	Over-bed table	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
E0277	Powered pressure-reducing air mattress	Prior Authorization Required	Medical Necessity	Letter of medical necessity including the anticipated length of time equipment will be required/needed, and reasoning equipment needed, as well as description of medical condition and mobility status
E0290	Hospital bed, fixed height, without side rails, with mattress	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	Letter of medical necessity containing the following information: Description of member's medical condition requiring use of equipment, including mobility status and anticipated length of time that member will require the equipment (no review needed if rental)
E0291	Hospital bed, fixed height, without side rails, without mattress	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	Letter of medical necessity containing the following information: Description of member's medical condition requiring use of equipment, including mobility status and anticipated length of time that member will require the equipment (no review needed if rental)
E0292	Hospital bed, variable height, hi-lo, without side rails, with mattress	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	Letter of medical necessity containing the following information: Description of member's medical condition requiring use of equipment, including mobility status and anticipated length of time that member will require the equipment (no review needed if rental)

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
E0293	Hospital bed, variable height, hi-lo, without side rails, without mattress	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	Letter of medical necessity containing the following information: Description of member's medical condition requiring use of equipment, including mobility status and anticipated length of time that member will require the equipment (no review needed if rental)
E0294	Hospital bed, semi-electric (head and foot adjustment), without side rails, with mattress	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	Letter of medical necessity containing the following information: Description of member's medical condition requiring use of equipment, including mobility status and anticipated length of time that member will require the equipment (no review needed if rental)
E0295	Hospital bed, semi-electric (head and foot adjustment), without side rails, without mattress	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	Letter of medical necessity containing the following information: Description of member's medical condition requiring use of equipment, including mobility status and anticipated length of time that member will require the equipment (no review needed if rental)
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 equipment needed/required
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 equipment needed/required
E0300	Pediatric crib, hospital grade, fully enclosed, with or without top enclosure	Prior Authorization Required	Medical Necessity	Letter of medical necessity, including mobility status and anticipated length of time equipment needed/required
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 including the anticipated length of time equipment will be required/needed, and reasoning equipment needed, as well as description of medical condition and mobility status

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
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 including the anticipated length of time equipment will be required/needed, and reasoning equipment needed, as well as description of medical condition and 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 including the anticipated length of time equipment will be required/needed, and reasoning equipment needed, as well as description of medical condition and mobility status
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 including the anticipated length of time equipment will be required/needed, and reasoning equipment needed, as well as description of medical condition and mobility status
E0315	Bed accessory: board, table, or support device, any type	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
E0316	Safety enclosure frame/canopy for use with hospital bed, any type	Prior Authorization Required	Medical Necessity	Letter of medical necessity including the anticipated length of time equipment will be required/needed, and reasoning equipment needed, as well as description of medical condition and mobility status
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 equipment needed/required; no review needed if rental
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 equipment needed/required; no review needed if rental

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
E0371	Nonpowered advanced pressure reducing overlay for mattress, standard mattress length and width	Prior Authorization Required	Medical Necessity	Letter of medical necessity including the anticipated length of time equipment will be required/needed, and reasoning equipment needed, as well as description of medical condition and mobility status
E0372	Powered air overlay for mattress, standard mattress length and width	Prior Authorization Required	Medical Necessity	Letter of medical necessity including the anticipated length of time equipment will be required/needed, and reasoning equipment needed, as well as description of medical condition and mobility status
E0373	Nonpowered advanced pressure reducing mattress	Prior Authorization Required	Medical Necessity	History and physical, including measurements and location of pressure ulcers
E0446	Topical oxygen delivery system, not otherwise specified, includes all supplies and accessories	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
E0490	Power source and control electronics unit for oral device/appliance for neuromuscular electrical stimulation of the tongue muscle, controlled by hardware remote	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	Submit history and physical, documentation of medical necessity.
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	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	Submit history and physical, documentation of medical necessity.
E0492	Power source and control electronics unit for oral device/appliance for neuromuscular electrical stimulation of the tongue muscle, controlled by phone application	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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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	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	Submit history and physical, documentation of medical necessity.
E0530	Electronic positional obstructive sleep apnea treatment, with sensor, includes all components and accessories, any type	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	Submit history and physical, documentation of medical necessity.
E0602	Breast pump, manual, any type	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
E0603	Breast pump, electric (AC and/or DC), any type	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
E0604	Breast pump, hospital grade, electric (AC and/or DC), any type	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
E0605	Vaporizer, room type	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
E0616	Implantable cardiac event recorder with memory, activator, and programmer	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	Submit history and physical, documentation of medical necessity.
E0621	Sling or seat, patient lift, canvas or nylon	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	Letter of medical necessity containing the following information: Description of member's medical condition requiring use of equipment, including mobility status and anticipated length of time that member will require the equipment
E0625	Patient lift, bathroom or toilet, not otherwise classified	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	Letter of medical necessity containing the following information: Description of member's medical condition requiring use of equipment, including mobility status and anticipated length of time that member will require the equipment
E0627	Seat lift mechanism incorporated into a combination lift-chair mechanism	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
E0629	Seat lift mechanism, nonelectric, any type	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.

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E0630	Patient lift; hydraulic or mechanical, includes any seat, sling, strap(s), or pad(s)	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	Letter of medical necessity containing the following information: Description of member's medical condition requiring use of equipment, including mobility status and anticipated length of time that member will require the equipment
E0637	Combination sit and stand system, any size, with seat lift feature, with or without wheels	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	Letter of medical necessity containing the following information: Description of member's medical condition requiring use of equipment, including mobility status and anticipated length of time that member will require the equipment
E0638	Standing frame system, one position (e.g., upright, supine or prone stander), any size including pediatric, with or without wheels	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	Letter of medical necessity containing the following information: Description of member's medical condition requiring use of equipment, including mobility status and anticipated length of time that member will require the equipment
E0639	Patient lift, moveable from room to room with disassembly and reassembly, includes all components/accessories	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	Letter of medical necessity containing the following information: Description of member's medical condition requiring use of equipment, including mobility status and anticipated length of time that member will require the equipment
E0641	Standing frame system, multi-position (e.g., three-way stander,), any size including pediatric, with or without wheels	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	Letter of medical necessity containing the following information: Description of member's medical condition requiring use of equipment, including mobility status and anticipated length of time that member will require the equipment
E0650	Pneumatic compressor, nonsegmental home model	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	Letter of medical necessity containing the following information: Description of member's medical condition requiring use of equipment, including mobility status and anticipated length of time that member will require the equipment

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E0651	Pneumatic compressor, segmental home model without calibrated gradient pressure	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	Letter of medical necessity containing the following information: Description of member's medical condition requiring use of equipment, including mobility status and anticipated length of time that member will require the equipment
E0652	Pneumatic compressor, segmental home model with calibrated gradient pressure	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	Letter of medical necessity containing the following information: Description of member's medical condition requiring use of equipment, including mobility status and anticipated length of time that member will require the equipment
E0656	Segmental pneumatic appliance for use with pneumatic compressor, trunk	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	Letter of medical necessity containing the following information: Description of member's medical condition requiring use of equipment, including mobility status and anticipated length of time that member will require the equipment
E0657	Segmental pneumatic appliance for use with pneumatic compressor, chest	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	Letter of medical necessity containing the following information: Description of member's medical condition requiring use of equipment, including mobility status and anticipated length of time that member will require the equipment
E0670	Segmental pneumatic appliance for use with pneumatic compressor, integrated, 2 full legs and trunk	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	Letter of medical necessity containing the following information: Description of member's medical condition requiring use of equipment, including mobility status and anticipated length of time that member will require the equipment
E0673	Segmental gradient pressure pneumatic appliance, half leg	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	Letter of medical necessity containing the following information: Description of member's medical condition requiring use of equipment, including mobility status and anticipated length of time that member will require the equipment

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E0675	Pneumatic compression device, high pressure, rapid inflation/deflation cycle, for arterial insufficiency (unilateral or bilateral system)	Pre-Service Review Required	Medical Necessity Review Required	History and Physical, Chart notes from ordering provider for medical necessity, including previously tried interventions and operative report if available
E0676	Intermittent limb compression device (includes all accessories), not otherwise specified	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical including comorbidities, previously tried clinical interventions and operative report, if available
E0720	Transcutaneous electrical nerve stimulation (TENS) device, 2 lead, localized stimulation	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	Letter of medical necessity, including condition being treated
E0730	Transcutaneous electrical nerve stimulation (TENS) device, 4 or more leads, for multiple nerve stimulation	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	Letter of medical necessity, including condition being treated
E0731	Form fitting garment for delivery of TENS or NMES, with conductive fibers separated from the patient's skin by layers of fabric	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	Letter of medical necessity, including condition being treated
E0732	Cranial electrotherapy stimulation (CES) system, any type	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	Submit history and physical, documentation of medical necessity.
E0733	Transcutaneous electrical nerve stimulator for electrical stimulation of the trigeminal nerve	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	Submit history and physical, documentation of medical necessity.
E0734	External upper limb tremor stimulator of the peripheral nerves of the wrist	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	Submit history and physical, documentation of medical necessity.
E0739	Rehabilitation system with interactive interface providing active assistance in rehabilitation therapy, includes all components and accessories, motors, microprocessors, sensors	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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E0740	Incontinence treatment system, pelvic floor stimulator, monitor, sensor, and/or trainer	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, and documentation of medical necessity, including plan of care and name of treatment system
E0745	Neuromuscular stimulator, electronic shock unit	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, including comorbidities, and previously tried clinical interventions and operative report, if available
E0746	Electromyography (EMG), biofeedback device	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
E0747	Osteogenesis stimulator, electrical, noninvasive, other than spinal applications	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, indicating location of the fracture and any comorbidities; if request is for a non-union fracture, include date of fracture, and serial radiographs detailing any history of healing, fracture gap, and docmentation of adequacy of immobiliazation. medical necessity review will be performed upon claims submission with supporting documentation
E0748	Osteogenic stimulator, electrical, non-invasive, spinal applications	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, indicating location of the fracture and any comorbidities; if request is for a non-union fracture, include date of fracture, and serial radiographs detailing any history of healing, fracture gap, and docmentation of adequacy of immobiliazation. medical necessity review will be performed upon claims submission with supporting documentation

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E0749	Osteogenesis stimulator, electrical, surgically implanted	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, indicating location of the fracture and any comorbidities; if request is for a non-union fracture, include date of fracture, and serial radiographs detailing any history of healing, fracture gap, and docmentation of adequacy of immobiliazation. medical necessity review will be performed upon claims submission with supporting documentation
E0760	Osteogenesis stimulator, low intensity ultrasound, non-invasive	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, indicating location of the fracture and any comorbidities; if request is for a non-union fracture, include date of fracture, and serial radiographs detailing any history of healing, fracture gap, and docmentation of adequacy of immobiliazation. medical necessity review will be performed upon claims submission with supporting documentation
E0761	Nonthermal pulsed high frequency radiowaves, high peak power electromagnetic energy treatment device	Medical necessity review will be performed upon claims submission with supporting documentation	Investigative	Submit procedure/testing report
E0762	Transcutaneous electrical joint stimulation device system, includes all accessories	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	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	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, documentation of medical necessity and plan of care

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E0765	FDA approved nerve stimulator, for treatment of nausea and vomiting	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, including comorbidities, and previously tried clinical interventions and operative report, if available
E0766	Electrical stimulation device used for cancer treatment, includes all accessories, any type	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	Submit history and physical, documentation of medical necessity.
E0769	Electrical stimulation or electromagnetic wound treatment device, not otherwise classified	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, documentation of medical necessity and plan of care
E0770	Functional electrical stimulator, transcutaneous stimulation of nerve, and/or muscle groups, any type, complete system, not otherwise specified	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	Letter of medical necessity, including description of medical condition, length of time equipment needed, and functional status, if applicable
E0936	Continuous passive motion exercise device for use other than knee	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	Submit history and physical, documentation of medical necessity.
E0983	Manual wheelchair accessory, power add-on to convert manual wheelchair to motorized wheelchair, joystick control	Prior Authorization Required	Medical Necessity	Documentation of medical condition, abilities/limitations as they relate to the equipment including reasoning for type of equipment (degree of independence/dependence, frequency, and nature of the activities performed), duration of the medical condition, experience (if any) using similar equipment, evaluation of upper extremity strength with documented inability to propel a manual wheelchair.

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E0984	Power add-on to convert manual wheelchair to motorized wheelchair, tiller cotnrol	Prior Authorization Required	Medical Necessity	Documentation of medical condition, abilities/limitations as they relate to the equipment including reasoning for type of equipment (degree of independence/dependence, frequency, and nature of the activities performed), duration of the medical condition, experience (if any) using similar equipment, evaluation of upper extremity strength with documented inability to propel a manual wheelchair.
E0985	Wheelchair accessory, seat lift mechanism	Prior Authorization Required	Medical Necessity	Letter of medical necessity, and documentation supporting the need for wheelchair accessory. Medical necessity review will be performed upon claims submission with supporting documentation
E0986	Manual wheelchair accessory, power assist system	Prior Authorization Required	Medical Necessity	Letter of medical necessity, and documentation supporting the need for wheelchair accessory. Medical necessity review will be performed upon claims submission with supporting documentation
E0988	Manual wheelchair accessory, lever-activated, wheel drive, pair	Advance Benefit Determination (ABD) recommended	Medical Necessity	Documentation of medical necessity, including an evaluation from a physical therapist/physiatrist/functional medicine provider. medical necessity review will be performed upon claims submission with supporting documentation
E1002	Power seating system, tilt only	Prior Authorization Required	Medical Necessity	Letter of medical necessity, and documentation supporting the need for wheelchair accessory. Medical necessity review will be performed upon claims submission with supporting documentation

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E1003	Wheelchair accessory, power seating system, recline only, without shear reduction	Prior Authorization Required	Medical Necessity	Letter of medical necessity, and documentation supporting the need for wheelchair accessory. Medical necessity review will be performed upon claims submission with supporting documentation
E1004	Wheelchair accessory, power seating system, recline only, with mechanical shear reduction	Prior Authorization Required	Medical Necessity	History and Physical and recent lab work. medical necessity review will be performed upon claims submission with supporting documentation
E1005	Wheelchair accessory, power seatng System, recline only, with power shear reduction	Prior Authorization Required	Medical Necessity	History and Physical and recent lab work. medical necessity review will be performed upon claims submission with supporting documentation
E1006	Power seating system, combination tilt and recline, without shear reduction	Prior Authorization Required	Medical Necessity	History and Physical and recent lab work. medical necessity review will be performed upon claims submission with supporting documentation
E1007	Power seating system, combination tilt and recline, with mechanical sheer reduction	Prior Authorization Required	Medical Necessity	Letter of medical necessity, and documentation supporting the need for wheelchair accessory. Medical necessity review will be performed upon claims submission with supporting documentation
E1008	Power seating system, combination tilt and recline, with power shear reduction	Prior Authorization Required	Medical Necessity	Letter of medical necessity, and documentation supporting the need for wheelchair accessory. Medical necessity review will be performed upon claims submission with supporting documentation
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, and documentation supporting the need for wheelchair accessory. Medical necessity review will be performed upon claims submission with supporting documentation

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E1010	Addition to power seating system, power leg elevation system, including leg rest, pair	Prior Authorization Required	Medical Necessity	Letter of medical necessity, and documentation supporting the need for wheelchair accessory. Medical necessity review will be performed upon claims submission with supporting documentation
E1011	Modification to pediatric size wheelchair, width adjustment package (not to be dispensed with initial chair)	Advance Benefit Determination (ABD) recommended	Medical Necessity	Letter of medical necessity, and documentation supporting the need for wheelchair accessory. Medical necessity review will be performed upon claims submission with supporting documentation
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, and documentation supporting the need for wheelchair accessory. Medical necessity review will be performed upon claims submission with supporting documentation
E1031	Rollabout chair, any and all types with casters five inches or greater	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical with letter of medical necessity 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, and evaluation of upper extremity strength)

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E1035	Multi-positional patient transfer system, with integrated seat, operated by care giver, patient weight capacity up to and including 300 lbs	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical with letter of medical necessity 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, and 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	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical with letter of medical necessity 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, and evaluation of upper extremity strength).
E1037	Transport chair, pediatric size	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical with letter of medical necessity 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, and evaluation of upper extremity strength)

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E1038	Transport chair, adult size, patient weight capacity up to an including 300 pounds	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical with letter of medical necessity 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, and evaluation of upper extremity strength)
E1039	Transport chair, adult size, heavy duty, patient weight capacity greater than 300 pounds	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical with letter of medical necessity 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, and evaluation of upper extremity strength)
E1161	Manual adult size wheelchair, includes tilt in space	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical with letter of medical necessity 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, and evaluation of upper extremity strength).

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E1230	Power operated vehicle (three- or four-wheel nonhighway), specify brand name and model number	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical condition/diagnosis, duration of the medical condition, and documentation of medical necessity of equipment
E1231	Wheelchair, pediatric size, tilt-in-space, rigid, adjustable, with seating system	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical with letter of medical necessity 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, and evaluation of upper extremity strength).
E1232	Wheelchair; Pediatric size, tilt-in-space, folding, adjustable, with seating system	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical with letter of medical necessity 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, and evaluation of upper extremity strength).

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
E1233	Pediatric size, tilt-in-space, rigid, adjustable, without seating system	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical with letter of medical necessity 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, and evaluation of upper extremity strength).
E1234	Pediatric size, tilt-in-space, folding adjustable with seating system	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical with letter of medical necessity 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, and evaluation of upper extremity strength).
E1235	Pediatric size, folding, adjustable, with seating system	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical with letter of medical necessity 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, and evaluation of upper extremity strength)

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Code List

Code	Description	Plan Review Requirement	Reviewed For	Records Request
E1236	Wheelchair, pediatric size, folding, adjustable, with seating system	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical with letter of medical necessity 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, and evaluation of upper extremity strength)
E1237	Pediatric size, rigid, adjustable, without seating system	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical with letter of medical necessity 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, and evaluation of upper extremity strength)
E1238	Pediatric size, folding, adjustable, without seating system	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical with letter of medical necessity 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, and evaluation of upper extremity strength)

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
E1239	Power wheelchair, pediatric size, not otherwise specified	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical condition/diagnosis, duration of the medical condition, and documentation of medical necessity of equipment. medical necessity review will be performed upon claims submission with supporting documentation
E1280	Heavy duty wheelchair; detachable arms, desk or full-length, elevating legrests	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical with letter of medical necessity 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, and evaluation of upper extremity strength)
E1300	Whirlpool, portable (overtub type)	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
E1301	Whirlpool tub, walk-in, portable	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
E1310	Whirlpool, nonportable (built-in type)	Non-covered Service	Not Covered	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	Allow per IHM when billed charge is less than $100. For billed charges greater than $100, submit the description of the item provided, and letter of medical necessity, including member's current medical condition
E1639	Scale, for dialysis, each	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.

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E1699	Dialysis equipment, not otherwise specified	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	Allow per IHM when billed charge is less than $300. For billed charges greater than $300, submit the description of item provided, and letter of medical necessity including member's current medical condition
E1841	Static progressive stretch shoulder device, with or without range of motion adjustment, includes all components and accessories	Medical necessity review will be performed upon claims submission with supporting documentation	Investigative	Letter of medical necessity containing the following information: Anticipated length of time that the member will need the equipment, the description of the member's medical condition detailing mobility status and the reason member is requiring the use of equipment, and surgical procedure description and date (if applicable)
E1902	Communication board, nonelectronic augmentative or alternative communication device	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
E1905	Virtual reality cognitive behavioral therapy device (CBT), including pre-programmed therapy software	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
E2001	Suction pump, home model, portable or stationary, electric, any type, for use with external urine and/or fecal management system	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
E2207	Wheelchair accessory, crutch and cane holder, each	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
E2301	Power wheelchair accessory, power standing system	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, and documentation of medical necessity. medical necessity review will be performed upon claims submission with supporting documentation

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E2310	Power wheelchair accessory, electronic connection between wheelchair controller and one power seating system motor, including all related electronics, indicator feature, mechanical function selection switch, and fixed mounting hardware	Prior Authorization Required	Medical Necessity	Letter of medical necessity, and documentation supporting the need for wheelchair accessory.
E2311	Electronic connection between wheelchair controller and two or more power seating system motors, including all related electronics, indicator	Prior Authorization Required	Medical Necessity	Letter of medical necessity, and documentation supporting the need for wheelchair accessory. Medical necessity review will be performed upon claims submission with supporting documentation
E2312	Power wheelchair accessory, hand or chin control interface, mini-proportional remote joystick, proportional, including fixed mounting hardware	Prior Authorization Required	Medical Necessity	Letter of medical necessity, and documentation supporting the need for wheelchair accessory
E2313	Wheelchairs (Manual or Motorized)	Prior Authorization Required	Medical Necessity	Letter of medical necessity, and documentation supporting the need for wheelchair accessory
E2321	Power wheelchair accessory, hand control interface, remote joystick, nonproportional, including all related electronics, mechanical stop switch, and fixed mounting hardware	Prior Authorization Required	Medical Necessity	Letter of medical necessity, and documentation supporting the need for wheelchair accessory
E2322	Power wheelchair accessory, hand control interface, multiple mechanical switches, nonproportional, including all related electronics, mechanical stop switch, and fixed mounting hardware	Prior Authorization Required	Medical Necessity	Letter of medical necessity, and documentation supporting the need for wheelchair accessory
E2323	Power wheelchair accessory, specialty joystick handle for hand control interface, prefabricated	Prior Authorization Required	Medical Necessity	Letter of medical necessity, and documentation supporting the need for wheelchair accessory
E2324	Power wheelchair accessory, chin cup for chin control interface	Prior Authorization Required	Medical Necessity	Letter of medical necessity, and documentation supporting the need for wheelchair accessory

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
E2325	Power wheelchair accessory, sip and puff interface, nonproportional, including all related electronics, mechanical stop switch, and manual swingaway mounting hardware	Prior Authorization Required	Medical Necessity	Letter of medical necessity, and documentation supporting the need for wheelchair accessory
E2326	Power wheelchair accessory, breath tube kit for sip and puff interface	Prior Authorization Required	Medical Necessity	Letter of medical necessity, and documentation supporting the need for wheelchair accessory
E2327	Power wheelchair accessory, head control interface, mechanical, proportional, including all related electronics, mechanical direction change switch, and fixed mounting hardware	Prior Authorization Required	Medical Necessity	Letter of medical necessity, and documentation supporting the need for wheelchair accessory
E2328	Power wheelchair accessory, head control or extremity control interface, electronic, proportional, including all related electronics and fixed mounting hardware	Prior Authorization Required	Medical Necessity	Letter of medical necessity, and documentation supporting the need for wheelchair accessory
E2329	Power wheelchair accessory, head control interface, contact switch mechanism, nonproportional, including all related electronics, and fixed mounting hardware	Prior Authorization Required	Medical Necessity	Letter of medical necessity, and documentation supporting the need for wheelchair accessory
E2330	Power wheelchair accessory, head control interface, proximity switch mechanism, nonproportional, including all related electronics, mechanical stop switch, mechanical direction change switch, head array, and fixed mounting hardware	Prior Authorization Required	Medical Necessity	Letter of medical necessity, and documentation supporting the need for wheelchair accessory
E2331	Power wheelchair accessory, attendant control, proportional, including all related electronics and fixed mounting hardware	Prior Authorization Required	Medical Necessity	Letter of medical necessity, and documentation supporting the need for wheelchair accessory. Medical necessity review will be performed upon claims submission with supporting documentation

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Code List

Code	Description	Plan Review Requirement	Reviewed For	Records Request
E2340	Power wheelchair accessory, nonstandard seat frame width, 20-23 in	Prior Authorization Required	Medical Necessity	Letter of medical necessity, and documentation supporting the need for wheelchair accessory
E2341	Power wheelchair accessory, nonstandard seat frame width, 24-27 in	Prior Authorization Required	Medical Necessity	Letter of medical necessity, and documentation supporting the need for wheelchair accessory. Medical necessity review will be performed upon claims submission with supporting documentation
E2342	Non-standard seat frame depth, 20 or 21 inches	Prior Authorization Required	Medical Necessity	Letter of medical necessity, and documentation supporting the need for wheelchair accessory. Medical necessity review will be performed upon claims submission with supporting documentation
E2343	Power wheelchair accessory, nonstandard seat frame depth, 22-25 in	Prior Authorization Required	Medical Necessity	Letter of medical necessity, and documentation supporting the need for wheelchair accessory. Medical necessity review will be performed upon claims submission with supporting documentation
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, and documentation supporting the need for wheelchair accessory
E2358	Power wheelchair accessory, group 34 nonsealed lead acid battery, each	Prior Authorization Required	Medical Necessity	Letter of medical necessity, and documentation supporting the need for wheelchair accessory. Medical necessity review will be performed upon claims submission with supporting documentation
E2359	Power wheelchair accessory, group 34 sealed lead acid battery, each (e.g., gel cell, absorbed glass mat)	Prior Authorization Required	Medical Necessity	Letter of medical necessity, and documentation supporting the need for wheelchair accessory

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E2360	Power wheelchair accessory, 22 NF nonsealed lead acid battery, each	Prior Authorization Required	Medical Necessity	Letter of medical necessity, and documentation supporting the need for wheelchair accessory. Medical necessity review will be performed upon claims submission with supporting documentation
E2361	Power wheelchair accessory, 22 NF sealed lead acid battery, each (e.g., gel cell, absorbed glassmat)	Prior Authorization Required	Medical Necessity	Letter of medical necessity, and documentation supporting the need for wheelchair accessory
E2362	Power wheelchair accessory, group 24 nonsealed lead acid battery, each	Prior Authorization Required	Medical Necessity	Letter of medical necessity, and documentation supporting the need for wheelchair accessory. Medical necessity review will be performed upon claims submission with supporting documentation
E2363	Power wheelchair accessory, group 24 sealed lead acid battery, each (e.g., gel cell, absorbed glassmat)	Prior Authorization Required	Medical Necessity	Letter of medical necessity, and documentation supporting the need for wheelchair accessory
E2364	Power wheelchair accessory, U-1 nonsealed lead acid battery, each	Prior Authorization Required	Medical Necessity	Letter of medical necessity, and documentation supporting the need for wheelchair accessory. Medical necessity review will be performed upon claims submission with supporting documentation
E2365	Power wheelchair accessory, U-1 sealed lead acid battery, each (e.g., gel cell, absorbed glassmat)	Prior Authorization Required	Medical Necessity	Letter of medical necessity, and documentation supporting the need for wheelchair accessory
E2366	Power wheelchair accessory, battery charger, single mode, for use with only one battery type, sealed or nonsealed, each	Prior Authorization Required	Medical Necessity	Letter of medical necessity, and documentation supporting the need for wheelchair accessory
E2367	Power wheelchair accessory, battery charger, dual mode, for use with either battery type, sealed or nonsealed, each	Prior Authorization Required	Medical Necessity	Letter of medical necessity, and documentation supporting the need for wheelchair accessory. Medical necessity review will be performed upon claims submission with supporting documentation

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
E2368	Power wheelchair component, motor, replacement only	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
E2369	Power wheelchair component, gear box, replacement only	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
E2370	Power wheelchair component, motor and gear box combination, replacement only	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
E2372	Power wheelchair accessory, group 27 nonsealed lead acid battery, each	Prior Authorization Required	Medical Necessity	Letter of medical necessity, and documentation supporting the need for wheelchair accessory
E2373	Power wheelchair accessory, hand or chin control interface, compact remote joystick, proportional, including fixed mounting hardware	Prior Authorization Required	Medical Necessity	Letter of medical necessity, and documentation supporting the need for wheelchair accessory
E2374	Power wheelchair accessory, hand or chin control interface, standard remote joystick (not including controller), replacement only	Prior Authorization Required	Medical Necessity	Letter of medical necessity, and documentation supporting the need for wheelchair accessory
E2375	Power wheelchair accessory, nonexpandable controller, including all related electronics and mounting hardware, replacement only	Prior Authorization Required	Medical Necessity	Letter of medical necessity, and documentation supporting the need for wheelchair accessory
E2376	Power wheelchair accessory, expandable controller, including all related electronics and mounting hardware, replacement only	Prior Authorization Required	Medical Necessity	Letter of medical necessity, and documentation supporting the need for wheelchair accessory
E2377	Power wheelchair accessory, expandable controller, including all related electronics and mounting hardware, upgrade provided at initial issue	Prior Authorization Required	Medical Necessity	Letter of medical necessity, and documentation supporting the need for wheelchair accessory
E2378	Power wheelchair component, actuator, replacement only	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
E2381	Power wheelchair accessory, pneumatic drive wheel tire, any size, replacement only, each	Prior Authorization Required	Medical Necessity	Letter of medical necessity, and documentation supporting the need for wheelchair accessory

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
E2382	Power wheelchair accessory, tube for pneumatic drive wheel tire, any size, replacement only, each	Prior Authorization Required	Medical Necessity	Letter of medical necessity, and documentation supporting the need for wheelchair accessory
E2383	Power wheelchair accessory, insert for pneumatic drive wheel tire (removable), any type, any size, replacement only, each	Prior Authorization Required	Medical Necessity	Letter of medical necessity, and documentation supporting the need for wheelchair accessory
E2384	Power wheelchair accessory, pneumatic caster tire, any size, replacement only, each	Prior Authorization Required	Medical Necessity	Letter of medical necessity, and documentation supporting the need for wheelchair accessory
E2385	Power wheelchair accessory, tube for pneumatic caster tire, any size, replacement only, each	Prior Authorization Required	Medical Necessity	Letter of medical necessity, and documentation supporting the need for wheelchair accessory
E2386	Power wheelchair accessory, foam filled drive wheel tire, any size, replacement only, each	Prior Authorization Required	Medical Necessity	Letter of medical necessity, and documentation supporting the need for wheelchair accessory
E2387	Power wheelchair accessory, foam filled caster tire, any size, replacement only, each	Prior Authorization Required	Medical Necessity	Letter of medical necessity, and documentation supporting the need for wheelchair accessory
E2388	Power wheelchair accessory, foam drive wheel tire, any size, replacement only, each	Prior Authorization Required	Medical Necessity	Letter of medical necessity, and documentation supporting the need for wheelchair accessory
E2389	Power wheelchair accessory, foam caster tire, any size, replacement only, each	Prior Authorization Required	Medical Necessity	Letter of medical necessity, and documentation supporting the need for wheelchair accessory
E2390	Power wheelchair accessory, solid (rubber/plastic) drive wheel tire, any size, replacement only, each	Prior Authorization Required	Medical Necessity	Letter of medical necessity, and documentation supporting the need for wheelchair accessory
E2391	Power wheelchair accessory, solid (rubber/plastic) caster tire (removable), any size, replacement only, each	Prior Authorization Required	Medical Necessity	Letter of medical necessity, and documentation supporting the need for wheelchair accessory
E2392	Power wheelchair accessory, solid (rubber/plastic) caster tire with integrated wheel, any size, replacement only, each	Prior Authorization Required	Medical Necessity	Letter of medical necessity, and documentation supporting the need for wheelchair accessory

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E2394	Power wheelchair accessory, drive wheel excludes tire, any size, replacement only, each	Prior Authorization Required	Medical Necessity	Letter of medical necessity, and documentation supporting the need for wheelchair accessory
E2395	Power wheelchair accessory, caster wheel excludes tire, any size, replacement only, each	Prior Authorization Required	Medical Necessity	Letter of medical necessity, and documentation supporting the need for wheelchair accessory
E2396	Power wheelchair accessory, caster fork, any size, replacement only, each	Prior Authorization Required	Medical Necessity	Letter of medical necessity, and documentation supporting the need for wheelchair accessory
E2397	Wheelchairs (Manual or Motorized)	Prior Authorization Required	Medical Necessity	Letter of medical necessity, and documentation supporting the need for wheelchair accessory
E2398	Wheelchair accessory, dynamic positioning hardware for back	Prior Authorization Required	Medical Necessity	Letter of medical necessity, and documentation supporting the need for wheelchair accessory
E2609	Custom fabricated wheelchair seat cushion, any size	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	Letter of medical necessity, and documentation supporting the need for wheelchair accessory
E2617	Custom fabricated wheelchair back cushion, any size, includes any type mounting hardware	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	Letter of medical necessity, and documentation supporting the need for wheelchair accessory
E3000	Speech volume modulation system, any type, including all components and accessories	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
G0076	Brief (20 minutes) care management home visit for a new patient. For use only in a Medicare-approved CMMI model (services must be furnished within a beneficiary's home, domiciliary, rest home, assisted living and/or nursing facility)	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
G0077	Limited (30 minutes) care management home visit for a	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.

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G0078	Moderate (45 minutes) care management home visit for a new patient. For use only in a Medicare-approved CMMI model (services must be furnished within a beneficiary's home, domiciliary, rest home, assisted living and/or nursing facility)	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
G0079	Comprehensive (60 minutes) care management home visit for a new patient. For use only in a Medicare-approved CMMI model (services must be furnished within a beneficiary's home, domiciliary, rest home, assisted living and/or nursing facility)	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
G0080	Extensive (75 minutes) care management home visit for a new patient. For use only in a Medicare-approved CMMI model (services must be furnished within a beneficiary's home, domiciliary, rest home, assisted living and/or nursing facility)	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
G0081	Brief (20 minutes) care management home visit for an existing patient. For use only in a Medicare-approved CMMI model (services must be furnished within a beneficiary's home, domiciliary, rest home, assisted living and/or nursing facility)	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
G0082	Limited (30 minutes) care management home visit for an existing patient. For use only in a Medicare-approved CMMI model (services must be furnished within a beneficiary's home, domiciliary, rest home, assisted living and/or nursing facility)	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.

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G0083	Moderate (45 minutes) care management home visit for an existing patient. For use only in a Medicare-approved CMMI model (services must be furnished within a beneficiary's home, domiciliary, rest home, assisted living and/or nursing facility)	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
G0084	Comprehensive (60 minutes) care management home visit for an existing patient. For use only in a Medicare-approved CMMI model (services must be furnished within a beneficiary's home, domiciliary, rest home, assisted living and/or nursing facility)	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
G0085	Extensive (75 minutes) care management home visit for an existing patient. For use only in a Medicare-approved CMMI model (services must be furnished within a beneficiary's home, domiciliary, rest home, assisted living and/or nursing facility)	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
G0086	Limited (30 minutes) care management home care plan oversight. For use only in a Medicare-approved CMMI model (services must be furnished within a beneficiary's home, domiciliary, rest home, assisted living and/or nursing facility)	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
G0087	Comprehensive (60 minutes) care management home care plan oversight. For use only in a Medicare-approved CMMI model (services must be furnished within a beneficiary's home, domiciliary, rest home, assisted living and/or nursing facility)	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.

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G0117	Glaucoma screening for high risk patients furnished by an optometrist or ophthalmologist	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
G0118	Glaucoma screening for high risk patient furnished under the direct supervision of an optometrist or ophthalmologist	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
G0127	Trimming of dystrophic nails, any number	Medical necessity review will be performed upon claims submission with supporting documentation	Potential Contract Exclusion	Chart notes from the ordering physician indicating medical necessity for the non-diabetic lesion removal and debridement
G0128	Direct (face-to-face with patient) skilled nursing services of a registered nurse provided in a comprehensive outpatient rehabilitation facility, each 10 minutes beyond the first 5 minutes	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
G0156	Services of home health/hospice aide in home health or hospice settings, each 15 minutes	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
G0175	Scheduled interdisciplinary team conference (minimum of three exclusive of patient care nursing staff) with patient present	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
G0237	Therapeutic procedures to increase strength or endurance of respiratory muscles, face-to-face, one-on-one, each 15 minutes (includes monitoring)	Prior Authorization Required	Medical Necessity	History and physical, operative report (if applicable), therapy notes and documentation of medical necessity including reasoning for rehab and treatment plan
G0238	Therapeutic procedures to improve respiratory function, other than described by G0237, one-on-one, face-to-face, per 15 minutes (includes monitoring)	Prior Authorization Required	Medical Necessity	History and physical, operative report (if applicable), therapy notes and documentation of medical necessity including reasoning for rehab and treatment plan
G0239	Therapeutic procedures to improve respiratory function or increase strength or endurance of respiratory muscles, two or more individuals (includes monitoring)	Prior Authorization Required	Medical Necessity	History and physical, operative report (if applicable), therapy notes and documentation of medical necessity including reasoning for rehab and treatment plan

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G0255	Current perception threshold/sensory nerve conduction test, (SNCT) per limb, any nerve	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
G0277	Hyperbaric oxygen under pressure, full body chamber, per 30 minute interval	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
G0288	Reconstruction, computed tomographic angiography of aorta for surgical planning for vascular surgery	Prior Authorization Required	Medical Necessity	Submit history and physical and documentation of medical necessity, and procedure/imaging report
G0293	Noncovered surgical procedure(s) using conscious sedation, regional, general, or spinal anesthesia in a Medicare qualifying clinical trial, per day	Non-covered Service	Not Covered	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	Not Covered	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	Medical necessity review will be performed upon claims submission with supporting documentation	Investigative	Submit procedure/testing report
G0305	Postdischarge pulmonary surgery services after LVRS, minimum of 6 days of services	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
G0327	Colorectal cancer screening; blood-based biomarker	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	Submit history and physical, documentation of medical necessity.
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	Medical necessity review will be performed upon claims submission with supporting documentation	Investigative	Submit procedure/testing report

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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	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
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	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, including functional capacity,location, if metastatic, and number of lesions. medical necessity review will be performed upon claims submission with supporting documentation
G0341	Percutaneous islet cell transplant, includes portal vein catheterization and infusion	Prior Authorization Required	Medical Necessity	If transplant approval on record, then provide date of transplant; if no transplant approval on record, then provide history and physical, transplant evaluation, and date of transplant
G0342	Laparoscopy for islet cell transplant, includes portal vein catheterization and infusion	Prior Authorization Required	Medical Necessity	If transplant approval on record, then provide date of transplant; if no transplant approval on record, then provide history and physical, transplant evaluation, and date of transplant
G0343	Laparotomy for islet cell transplant, includes portal vein catheterization and infusion	Prior Authorization Required	Medical Necessity	If transplant approval on record, then provide date of transplant; if no transplant approval on record, then provide history and physical, transplant evaluation, and date of transplant
G0372	Physician service required to establish and document the need for a power mobility device	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
G0398	Home sleep study test (HST) with type II portable monitor, unattended; minimum of 7 channels: EEG, EOG, EMG, ECG/heart reate,airflow,respiratory effort and oxygen saturation	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	No review for members 18 years and older; for members 17 years and younger, submit history and physical, and documentation of medical necessity

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G0399	Home sleep test (HST) with type III portable monitor, unattended; minimum of 4 channels: 2 respiratory movement/airflow, 1 ECG/heart rate and 1oxygen saturation	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	No review for members 18 years and older; for members 17 years and younger, submit history and physical, and documentation of medical necessity
G0400	Home sleep test (HST) with type IV portable monitor, unattended; minimum of 3 channels	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	No review for members 18 years and older; for members 17 years and younger, submit history and physical, and documentation of medical necessity
G0422	Intensive cardiac rehabilitation; with or without continuous ECG monitoring with exercise, per session	Prior Authorization Required	Medical Necessity	History and physical, operative report (if applicable), therapy notes and documentation of medical necessity including reasoning for rehab and treatment plan
G0423	Intensive cardiac rehabilitation; with or without continuous ECG monitoring; without exercise, per session	Prior Authorization Required	Medical Necessity	History and physical, operative report (if applicable), therapy notes and documentation of medical necessity including reasoning for rehab and treatment plan
G0428	Collagen meniscus implant procedure for filling meniscal defects (e.g., CMI, collagen scaffold, Menaflex)	Prior Authorization Required	Investigative	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, conservative measures, operative report, and anesthesia report
G0429	Dermal filler injection(s) for the treatment of facial lipodystrophy syndrome (LDS) (e.g., as a result of highly active antiretroviral therapy)	Medical necessity review will be performed upon claims submission with supporting documentation	Potential Contract Exclusion	Submit history and physical, documentation of medical necessity.
G0452	Molecular pathology procedure; physician interpretation and report	Prior Authorization Required	Medical Necessity Review Required	History and physical, and chart notes from ordering provider with reason for testing

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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)	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	Submit history and physical, documentation of medical necessity.
G0459	Inpatient telehealth pharmacologic management, including prescription, use, and review of medication with no more than minimal medical psychotherapy	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
G0460	Autologous platelet rich plasma for chronic wounds/ulcers, including phlebotomy, centrifugation, and all other preparatory procedures, administration and dressings, per treatment	Medical necessity review will be performed upon claims submission with supporting documentation	Investigative	Submit history and physical, documentation of medical necessity.
G0465	Autologous platelet rich plasma (PRP) or other blood-derived product for diabetic chronic wounds/ulcers, using an FDA-cleared device for this indication, (includes, as applicable: administration, dressings, phlebotomy, centrifugation or mixing, and all other preparatory procedures, per treatment)	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	Submit history and physical, documentation of medical necessity.
G0506	Comprehensive assessment of and care planning for patients requiring chronic care management services (list separately in addition to primary monthly care management service)	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
G0519	Management of new patient-caregiver dyad with dementia, low complexity, for use in CMMI model	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
G0520	Management of new patient-caregiver dyad with dementia, moderate complexity, for use in CMMI model	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.

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G0521	Management of new patient-caregiver dyad with dementia, high complexity, for use in CMMI model	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
G0522	Management of a new patient with dementia, low complexity, for use in CMMI model	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
G0523	Management of a new patient with dementia, moderate to high complexity, for use in CMMI model	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
G0524	Management of established patient-caregiver dyad with dementia, low complexity, for use in CMMI model	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
G0525	Management of established patient-caregiver dyad with dementia, moderate complexity, for use in CMMI model	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
G0526	Management of established patient-caregiver dyad with dementia, high complexity, for use in CMMI model	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
G0527	Management of established patient with dementia, low complexity, for use in CMMI model	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
G0528	Management of established patient with dementia, moderate to high complexity, for use in CMMI model	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
G0529	In-home respite care, 4-hour unit, for use in CMMI model	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
G0530	Adult day center, 8-hour unit, for use in CMMI model	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
G0531	Facility-based respite, 24-hour unit, for use in CMMI model	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
G0539	Caregiver training in behavior management/modification for caregiver(s) of patients with a mental or physical health diagnosis, administered by physician or other qualified health care professional (without the patient present), face-to-face; initial 30 minutes	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.

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G0540	Caregiver training in behavior management/modification for parent(s)/guardian(s)/caregiver(s) of patients with a mental or physical health diagnosis, administered by physician or other qualified health care professional (without the patient present), face-to-face; each additional 15 minutes	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
G0541	Caregiver training in direct care strategies and techniques to support care for patients with an ongoing condition or illness and to reduce complications (including, but not limited to, techniques to prevent decubitus ulcer formation, wound care, and infection control) (without the patient present), face-to-face; initial 30 minutes	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
G0542	Caregiver training in direct care strategies and techniques to support care for patients with an ongoing condition or illness and to reduce complications (including, but not limited to, techniques to prevent decubitus ulcer formation, wound care, and infection control) (without the patient present), face-to-face; each additional 15 minutes	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
G0543	Group caregiver training in direct care strategies and techniques to support care for patients with an ongoing condition or illness and to reduce complications (including, but not limited to, techniques to prevent decubitus ulcer formation, wound care, and infection control) (without the patient present), face-to-face with multiple sets of caregivers	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.

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G0546	Interprofessional telephone/internet/electronic health record assessment and management service provided by a practitioner in a specialty whose covered services are limited by statute to services for the diagnosis and treatment of mental illness, including a verbal and written report to the patient's treating/requesting practitioner; 5-10 minutes of medical consultative discussion and review	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
G0547	Interprofessional telephone/internet/electronic health record assessment and management service provided by a practitioner in a specialty whose covered services are limited by statute to services for the diagnosis and treatment of mental illness, including a verbal and written report to the patient's treating/requesting practitioner; 11-20 minutes of medical consultative discussion and review	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
G0548	Interprofessional telephone/internet/electronic health record assessment and management service provided by a practitioner in a specialty whose covered services are limited by statute to services for the diagnosis and treatment of mental illness, including a verbal and written report to the patient's treating/requesting practitioner; 21-30 minutes of medical consultative discussion and review	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.

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G0549	Interprofessional telephone/internet/electronic health record assessment and management service provided by a practitioner in a specialty whose covered services are limited by statute to services for the diagnosis and treatment of mental illness, including a verbal and written report to the patient's treating/requesting practitioner; 31 or more minutes of medical consultative discussion and review	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
G0550	Interprofessional telephone/internet/electronic health record assessment and management service provided by a practitioner in a specialty whose covered services are limited by statute to services for the diagnosis and treatment of mental illness, including a written report to the patient's treating/requesting practitioner, 5 minutes or more of medical consultative time	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
G0551	Interprofessional telephone/internet/electronic health record referral service(s) provided by a treating/requesting practitioner in a specialty whose covered services are limited by statute to services for the diagnosis and treatment of mental illness, 30 minutes	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
G0552	Supply of digital mental health treatment device and initial education and onboarding, per course of treatment that augments a behavioral therapy plan	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.

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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	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
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	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.

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G0556	Advanced primary care management services for a patient with one chronic condition [expected to last at least 12 months, or until the death of the patient, which place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline], or fewer, provided by clinical staff and directed by a physician or other qualified health care professional who is responsible for all primary care and serves as the continuing focal point for all needed health care services, per calendar month, with the following elements, as appropriate	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
G0557	Advanced primary care management services for a patient with multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, which place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, provided by clinical staff and directed by a physician or other qualified health care professional who is responsible for all primary care and serves as the continuing focal point for all needed health care services, per calendar month, with the following elements, as appropriate	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.

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G0558	Advanced primary care management services for a patient that is a Qualified Medicare Beneficiary (QMB) with multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, which place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, provided by clinical staff and directed by a physician or other qualified health care professional who is responsible for all primary care and serves as the continuing focal point for all needed health care services, per calendar month, with the following elements, as appropriate	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
G2000	Blinded administration of convulsive therapy procedure, either electroconvulsive therapy (ECT, current covered gold standard) or magnetic seizure therapy (MST, noncovered experimental therapy), performed in an approved IDE-based clinical trial, per treatment session	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
G2001	Brief (20 minutes) in-home visit for a new patient postdischarge. For use only in a Medicare-approved CMMI model. (Services must be furnished within a beneficiary's home, domiciliary, rest home, assisted living and/or nursing facility within 90 days following discharge from an inpatient facility and no more than nine times.)	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.

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G2002	Limited (30 minutes) in-home visit for a new patient postdischarge. For use only in a Medicare-approved CMMI model. (Services must be furnished within a beneficiary's home, domiciliary, rest home, assisted living and/or nursing facility within 90 days following discharge from an inpatient facility and no more than nine times.)	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
G2003	Moderate (45 minutes) in-home visit for a new patient postdischarge. For use only in a Medicare-approved CMMI model. (Services must be furnished within a beneficiary's home, domiciliary, rest home, assisted living and/or nursing facility within 90 days following discharge from an inpatient facility and no more than nine times.)	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
G2004	Comprehensive (60 minutes) in-home visit for a new patient postdischarge. For use only in a Medicare-approved CMMI model. (Services must be furnished within a beneficiary's home, domiciliary, rest home, assisted living and/or nursing facility within 90 days following discharge from an inpatient facility and no more than nine times.)	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
G2005	Extensive (75 minutes) in-home visit for a new patient postdischarge. For use only in a Medicare-approved CMMI model. (Services must be furnished within a beneficiary's home, domiciliary, rest home, assisted living and/or nursing facility within 90 days following discharge from an inpatient facility and no more than nine times.)	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.

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G2006	Brief (20 minutes) in-home visit for an existing patient postdischarge. For use only in a Medicare-approved CMMI model. (Services must be furnished within a beneficiary's home, domiciliary, rest home, assisted living and/or nursing facility within 90 days following discharge from an inpatient facility and no more than nine times.)	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
G2007	Limited (30 minutes) in-home visit for an existing patient postdischarge. For use only in a Medicare-approved CMMI model. (Services must be furnished within a beneficiary's home, domiciliary, rest home, assisted living and/or nursing facility within 90 days following discharge from an inpatient facility and no more than nine times.)	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
G2008	Moderate (45 minutes) in-home visit for an existing patient postdischarge. For use only in a Medicare-approved CMMI model. (Services must be furnished within a beneficiary's home, domiciliary, rest home, assisted living and/or nursing facility within 90 days following discharge from an inpatient facility and no more than nine times.)	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
G2009	Comprehensive (60 minutes) in-home visit for an existing patient postdischarge. For use only in a Medicare-approved CMMI model. (Services must be furnished within a beneficiary's home, domiciliary, rest home, assisted living and/or nursing facility within 90 days following discharge from an inpatient facility and no more than nine times.)	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.

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G2010	Remote evaluation of recorded video and/or images submitted by an established patient (e.g., store and forward), including interpretation with follow-up with the patient within 24 business hours, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
G2013	Extensive (75 minutes) in-home visit for an existing patient postdischarge. For use only in a Medicare-approved CMMI model. (Services must be furnished within a beneficiary's home, domiciliary, rest home, assisted living and/or nursing facility within 90 days following discharge from an inpatient facility and no more than nine times.)	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
G2014	Limited (30 minutes) care plan oversight. For use only in a Medicare-approved CMMI model. (Services must be furnished within a beneficiary's home, domiciliary, rest home, assisted living and/or nursing facility within 90 days following discharge from an inpatient facility and no more than nine times.)	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
G2015	Comprehensive (60 minutes) home care plan oversight. For use only in a Medicare-approved CMMI model. (Services must be furnished within a beneficiary's home, domiciliary, rest home, assisted living and/or nursing facility within 90 days following discharge from an inpatient facility.)	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.

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G2064	Comprehensive care management services for a single high risk disease, e.g., principal care management, at least 30 minutes of physician or other qualified health care professional time per calendar month with the following elements: one complex chronic condition lasting at least 3 months, which is the focus of the care plan, the condition is of sufficient severity to place patient at risk of hospitalization or have been the cause of a recent hospitalization, the condition requires development or revision of disease specific care plan, the condition requires frequent adjustments in the medication regimen, and/or the management of the condition is unusually complex due to comorbidities	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.

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G2065	Comprehensive care management for a single high risk disease services, e.g., principal care management, at least 30 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month with the following elements: one complex chronic condition lasting at least 3 months, which is the focus of the care plan, the condition is of sufficient severity to place patient at risk of hospitalization or have been cause of a recent hospitalization, the condition requires development or revision of disease-specific care plan, the condition requires frequent adjustments in the medication regimen, and/or the management of the condition is unusually complex due to comorbidities	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
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	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, and documentation of medical necessity. medical necessity review will be performed upon claims submission with supporting documentation
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	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, and documentation of medical necessity. medical necessity review will be performed upon claims submission with supporting documentation

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G2168	Services performed by a physical therapist assistant in the home health setting in the delivery of a safe and effective physical therapy maintenance program, each 15 minutes	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
G2169	Services performed by an occupational therapist assistant in the home health setting in the delivery of a safe and effective occupational therapy maintenance program, each 15 minutes	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
G2172	All inclusive payment for services related to highly coordinated and integrated opioid use disorder (OUD) treatment services furnished for the demonstration project	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
G2250	Remote assessment of recorded video and/or images submitted by an established patient (e.g., store and forward), including interpretation with follow-up with the patient within 24 business hours, not originating from a related service provided within the previous 7 days nor leading to a service or procedure within the next 24 hours or soonest available appointment	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
G2251	Brief communication technology-based service, e.g. virtual check-in, by a qualified health care professional who cannot report evaluation and management services, provided to an established patient, not originating from a related service provided within the previous 7 days nor leading to a service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of clinical discussion	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.

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G9001	Coordinated care fee, initial rate	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
G9002	Coordinated care fee, maintenance rate	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
G9003	Coordinated care fee, risk adjusted high, initial	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
G9004	Coordinated care fee, risk adjusted low, initial	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
G9005	Coordinated care fee, risk adjusted maintenance	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
G9006	Coordinated care fee, home monitoring	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
G9007	Coordinated care fee, scheduled team conference	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
G9008	Coordinated care fee, physician coordinated care oversight services	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
G9009	Coordinated care fee, risk adjusted maintenance, Level 3	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
G9010	Coordinated care fee, risk adjusted maintenance, Level 4	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
G9011	Coordinated care fee, risk adjusted maintenance, Level 5	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
G9012	Other specified case management service not elsewhere classified	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
G9016	Smoking cessation counseling, individual, in the absence of or in addition to any other evaluation and management service, per session (6-10 minutes)	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.

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Code List

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G9096	Oncology; disease status; esophageal cancer, limited to adenocarcinoma or squamous cell carcinoma as predominant cell type; extent of disease initially established as T1-T3, N0-N1 or NX (prior to neoadjuvant therapy, if any) with no evidence of disease progression, recurrence, or metastases (for use in a Medicare-approved demonstration project)	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	Submit history and physical, documentation of medical necessity.
G9097	Oncology; disease status; esophageal cancer, limited to adenocarcinoma or squamous cell carcinoma as predominant cell type; extent of disease initially established as T4, any N, M0 (prior to neoadjuvant therapy, if any) with no evidence of disease progression, recurrence, or metastases (for use in a Medicare-approved demonstration project)	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	Submit history and physical, documentation of medical necessity.
G9098	Oncology; disease status; esophageal cancer, limited to adenocarcinoma or squamous cell carcinoma as predominant cell type; M1 at diagnosis, metastatic, locally recurrent, or progressive (for use in a Medicare-approved demonstration project)	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 List

Code	Description	Plan Review Requirement	Reviewed For	Records Request
G9140	Frontier Extended Stay Clinic demonstration; for a patient stay in a clinic approved for the CMS demonstration project; the following measures should be present: the stay must be equal to or greater than 4 hours; weather or other conditions must prevent transfer or the case falls into a category of monitoring and observation cases that are permitted by the rules of the demonstration; there is a maximum Frontier Extended Stay Clinic (FESC) visit of 48 hours, except in the case when weather or other conditions prevent transfer; payment is made on each period up to 4 hours, after the first 4 hours	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	Submit history and physical, documentation of medical necessity.
G9143	Warfarin responsiveness testing by genetic technique using any method, any number of specimen(s)	Prior Authorization Required	Medical Necessity Review Required	History and physical, and chart notes from ordering provider with reason for testing
G9148	National Committee for Quality Assurance-Level 1 Medical Home	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
G9149	National Committee for Quality Assurance-Level 2 Medical Home	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
G9150	National Committee for Quality Assurance-Level 3 Medical Home	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
G9151	MAPCP Demonstration-state provided services	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
G9152	MAPCP Demonstration-Community Health Teams	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
G9153	MAPCP Demonstration-Physician Incentive Pool	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.

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Code List

Code	Description	Plan Review Requirement	Reviewed For	Records Request
G9481	Remote in-home visit for the evaluation and management of a new patient for use only in a Medicare-approved CMS Innovation Center Demonstration Project, which requires these three key components: a problem focused history; a problem focused examination; straightforward medical decision making, furnished in real time using interactive audio and video technology. Counseling and coordination of care with other physicians, other qualified health care professionals or agencies are provided consistent with the nature of the problem(s) and the needs of the patient or the family or both. Usually, the presenting problem(s) are self limited or minor. Typically, 10 minutes are spent with the patient or family or both via real time, audio and video intercommunications technology	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.

To search: Use CTRL+F for PCs or Command+F for Macs, and type in the code.
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All non-specific codes are reviewed retrospectively.
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Code List

Code	Description	Plan Review Requirement	Reviewed For	Records Request
G9482	Remote in-home visit for the evaluation and management of a new patient for use only in a Medicare-approved CMS Innovation Center Demonstration Project, which requires these three key components: an expanded problem focused history; an expanded problem focused examination; straightforward medical decision making, furnished in real time using interactive audio and video technology. Counseling and coordination of care with other physicians, other qualified health care professionals or agencies are provided consistent with the nature of the problem(s) and the needs of the patient or the family or both. Usually, the presenting problem(s) are of low to moderate severity. Typically, 20 minutes are spent with the patient or family or both via real time, audio and video intercommunications technology	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.

To search: Use CTRL+F for PCs or Command+F for Macs, and type in the code.
If no results are found, the code doesn't require review related to a medical policy.
All non-specific codes are reviewed retrospectively.
Please note that any planned inpatient stay always requires Precertification.
Items with PA require review and approval before the service is performed.

Code List

Code	Description	Plan Review Requirement	Reviewed For	Records Request
G9483	Remote in-home visit for the evaluation and management of a new patient for use only in a Medicare-approved CMS Innovation Center Demonstration Project, which requires these three key components: a detailed history; a detailed examination; medical decision making of low complexity, furnished in real time using interactive audio and video technology. Counseling and coordination of care with other physicians, other qualified health care professionals or agencies are provided consistent with the nature of the problem(s) and the needs of the patient or the family or both. Usually, the presenting problem(s) are of moderate severity. Typically, 30 minutes are spent with the patient or family or both via real time, audio and video intercommunications technology	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.

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If no results are found, the code doesn't require review related to a medical policy.
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Items with PA require review and approval before the service is performed.

Code List

Code	Description	Plan Review Requirement	Reviewed For	Records Request
G9484	Remote in-home visit for the evaluation and management of a new patient for use only in a Medicare-approved CMS Innovation Center Demonstration Project, which requires these three key components: a comprehensive history; a comprehensive examination; medical decision making of moderate complexity, furnished in real time using interactive audio and video technology. Counseling and coordination of care with other physicians, other qualified health care professionals or agencies are provided consistent with the nature of the problem(s) and the needs of the patient or the family or both. Usually, the presenting problem(s) are of moderate to high severity. Typically, 45 minutes are spent with the patient or family or both via real time, audio and video intercommunications technology	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.

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Code List

Code	Description	Plan Review Requirement	Reviewed For	Records Request
G9485	Remote in-home visit for the evaluation and management of a new patient for use only in a Medicare-approved CMS Innovation Center Demonstration Project, which requires these three key components: a comprehensive history; a comprehensive examination; medical decision making of high complexity, furnished in real time using interactive audio and video technology. Counseling and coordination of care with other physicians, other qualified health care professionals or agencies are provided consistent with the nature of the problem(s) and the needs of the patient or the family or both. Usually, the presenting problem(s) are of moderate to high severity. Typically, 60 minutes are spent with the patient or family or both via real time, audio and video intercommunications technology	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.

To search: Use CTRL+F for PCs or Command+F for Macs, and type in the code.
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Code List

Code	Description	Plan Review Requirement	Reviewed For	Records Request
G9486	Remote in-home visit for the evaluation and management of an established patient for use only in a Medicare-approved CMS Innovation Center Demonstration Project, which requires at least two of the following three key components: a problem focused history; a problem focused examination; straightforward medical decision making, furnished in real time using interactive audio and video technology. Counseling and coordination of care with other physicians, other qualified health care professionals or agencies are provided consistent with the nature of the problem(s) and the needs of the patient or the family or both. Usually, the presenting problem(s) are self limited or minor. Typically, 10 minutes are spent with the patient or family or both via real time, audio and video intercommunications technology	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.

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Code List

Code	Description	Plan Review Requirement	Reviewed For	Records Request
G9487	Remote in-home visit for the evaluation and management of an established patient for use only in a Medicare-approved CMS Innovation Center Demonstration Project, which requires at least two of the following three key components: an expanded problem focused history; an expanded problem focused examination; medical decision making of low complexity, furnished in real time using interactive audio and video technology. Counseling and coordination of care with other physicians, other qualified health care professionals or agencies are provided consistent with the nature of the problem(s) and the needs of the patient or the family or both. Usually, the presenting problem(s) are of low to moderate severity. Typically, 15 minutes are spent with the patient or family or both via real time, audio and video intercommunications technology	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.

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Code List

Code	Description	Plan Review Requirement	Reviewed For	Records Request
G9488	Remote in-home visit for the evaluation and management of an established patient for use only in a Medicare-approved CMS Innovation Center Demonstration Project, which requires at least two of the following three key components: a detailed history; a detailed examination; medical decision making of moderate complexity, furnished in real time using interactive audio and video technology. Counseling and coordination of care with other physicians, other qualified health care professionals or agencies are provided consistent with the nature of the problem(s) and the needs of the patient or the family or both. Usually, the presenting problem(s) are of moderate to high severity. Typically, 25 minutes are spent with the patient or family or both via real time, audio and video intercommunications technology	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.

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Code List

Code	Description	Plan Review Requirement	Reviewed For	Records Request
G9489	Remote in-home visit for the evaluation and management of an established patient for use only in a Medicare-approved CMS Innovation Center Demonstration Project, which requires at least two of the following three key components: a comprehensive history; a comprehensive examination; medical decision making of high complexity, furnished in real time using interactive audio and video technology. Counseling and coordination of care with other physicians, other qualified health care professionals or agencies are provided consistent with the nature of the problem(s) and the needs of the patient or the family or both. Usually, the presenting problem(s) are of moderate to high severity. Typically, 40 minutes are spent with the patient or family or both via real time, audio and video intercommunications technology	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.

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Code List

Code	Description	Plan Review Requirement	Reviewed For	Records Request
G9490	CMS Innovation Center Models, home visit for patient assessment performed by clinical staff for an individual not considered homebound, including, but not necessarily limited to patient assessment of clinical status, safety/fall prevention, functional status/ambulation, medication reconciliation/management, compliance with orders/plan of care, performance of activities of daily living, and ensuring beneficiary connections to community and other services. (For use only in Medicare-approved CMS Innovation Center Models); may not be billed for a 30 day period covered by a transitional care management code	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
G9873	First Medicare Diabetes Prevention Program (MDPP) core session was attended by an MDPP beneficiary under the MDPP Expanded Model (EM). A core session is an MDPP service that: (1) is furnished by an MDPP supplier during months 1 through 6 of the MDPP services period; (2) is approximately 1 hour in length; and (3) adheres to a CDC-approved DPP curriculum for core sessions	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.

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Code List

Code	Description	Plan Review Requirement	Reviewed For	Records Request
G9874	Four total Medicare Diabetes Prevention Program (MDPP) core sessions were attended by an MDPP beneficiary under the MDPP Expanded Model (EM). A core session is an MDPP service that: (1) is furnished by an MDPP supplier during months 1 through 6 of the MDPP services period; (2) is approximately 1 hour in length; and (3) adheres to a CDC-approved DPP curriculum for core sessions	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
G9875	Nine total Medicare Diabetes Prevention Program (MDPP) core sessions were attended by an MDPP beneficiary under the MDPP Expanded Model (EM). A core session is an MDPP service that: (1) is furnished by an MDPP supplier during months 1 through 6 of the MDPP services period; (2) is approximately 1 hour in length; and (3) adheres to a CDC-approved DPP curriculum for core sessions	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.

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Code List

Code	Description	Plan Review Requirement	Reviewed For	Records Request
G9876	Two Medicare Diabetes Prevention Program (MDPP) core maintenance sessions (MS) were attended by an MDPP beneficiary in months (mo) 7-9 under the MDPP Expanded Model (EM). A core maintenance session is an MDPP service that: (1) is furnished by an MDPP supplier during months 7 through 12 of the MDPP services period; (2) is approximately 1 hour in length; and (3) adheres to a CDC-approved DPP curriculum for maintenance sessions. The beneficiary did not achieve at least 5% weight loss (WL) from his/her baseline weight, as measured by at least one in-person weight measurement at a core maintenance session in months 7-9	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
G9877	Two Medicare Diabetes Prevention Program (MDPP) core maintenance sessions (MS) were attended by an MDPP beneficiary in months (mo) 10-12 under the MDPP Expanded Model (EM). A core maintenance session is an MDPP service that: (1) is furnished by an MDPP supplier during months 7 through 12 of the MDPP services period; (2) is approximately 1 hour in length; and (3) adheres to a CDC-approved DPP curriculum for maintenance sessions. The beneficiary did not achieve at least 5% weight loss (WL) from his/her baseline weight, as measured by at least one in-person weight measurement at a core maintenance session in months 10-12	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.

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Code List

Code	Description	Plan Review Requirement	Reviewed For	Records Request
G9878	Two Medicare Diabetes Prevention Program (MDPP) core maintenance sessions (MS) were attended by an MDPP beneficiary in months (mo) 7-9 under the MDPP Expanded Model (EM). A core maintenance session is an MDPP service that: (1) is furnished by an MDPP supplier during months 7 through 12 of the MDPP services period; (2) is approximately 1 hour in length; and (3) adheres to a CDC-approved DPP curriculum for maintenance sessions. The beneficiary achieved at least 5% weight loss (WL) from his/her baseline weight, as measured by at least one in-person weight measurement at a core maintenance session in months 7-9	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
G9879	Two Medicare Diabetes Prevention Program (MDPP) core maintenance sessions (MS) were attended by an MDPP beneficiary in months (mo) 10-12 under the MDPP Expanded Model (EM). A core maintenance session is an MDPP service that: (1) is furnished by an MDPP supplier during months 7 through 12 of the MDPP services period; (2) is approximately 1 hour in length; and (3) adheres to a CDC-approved DPP curriculum for maintenance sessions. The beneficiary achieved at least 5% weight loss (WL) from his/her baseline weight, as measured by at least one in-person weight measurement at a core maintenance session in months 10-12	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.

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Code List

Code	Description	Plan Review Requirement	Reviewed For	Records Request
G9880	The MDPP beneficiary achieved at least 5% weight loss (WL) from his/her baseline weight in months 1-12 of the MDPP services period under the MDPP Expanded Model (EM). This is a one-time payment available when a beneficiary first achieves at least 5% weight loss from baseline as measured by an in-person weight measurement at a core session or core maintenance session	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
G9881	The MDPP beneficiary achieved at least 9% weight loss (WL) from his/her baseline weight in months 1-24 under the MDPP Expanded Model (EM). This is a one-time payment available when a beneficiary first achieves at least 9% weight loss from baseline as measured by an in-person weight measurement at a core session, core maintenance session, or ongoing maintenance session	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.

To search: Use CTRL+F for PCs or Command+F for Macs, and type in the code.
If no results are found, the code doesn't require review related to a medical policy.
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Code List

Code	Description	Plan Review Requirement	Reviewed For	Records Request
G9882	Two Medicare Diabetes Prevention Program (MDPP) ongoing maintenance sessions (MS) were attended by an MDPP beneficiary in months (mo) 13-15 under the MDPP Expanded Model (EM). An ongoing maintenance session is an MDPP service that: (1) is furnished by an MDPP supplier during months 13 through 24 of the MDPP services period; (2) is approximately 1 hour in length; and (3) adheres to a CDC-approved DPP curriculum for maintenance sessions. The beneficiary maintained at least 5% weight loss (WL) from his/her baseline weight, as measured by at least one in-person weight measurement at an ongoing maintenance session in months 13-15	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
G9883	Two Medicare Diabetes Prevention Program (MDPP) ongoing maintenance sessions (MS) were attended by an MDPP beneficiary in months (mo) 16-18 under the MDPP Expanded Model (EM). An ongoing maintenance session is an MDPP service that: (1) is furnished by an MDPP supplier during months 13 through 24 of the MDPP services period; (2) is approximately 1 hour in length; and (3) adheres to a CDC-approved DPP curriculum for maintenance sessions. The beneficiary maintained at least 5% weight loss (WL) from his/her baseline weight, as measured by at least one in-person weight measurement at an ongoing maintenance session in months 16-18	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.

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Code List

Code	Description	Plan Review Requirement	Reviewed For	Records Request
G9884	Two Medicare Diabetes Prevention Program (MDPP) ongoing maintenance sessions (MS) were attended by an MDPP beneficiary in months (mo) 19-21 under the MDPP Expanded Model (EM). An ongoing maintenance session is an MDPP service that: (1) is furnished by an MDPP supplier during months 13 through 24 of the MDPP services period; (2) is approximately 1 hour in length; and (3) adheres to a CDC-approved DPP curriculum for maintenance sessions. The beneficiary maintained at least 5% weight loss (WL) from his/her baseline weight, as measured by at least one in-person weight measurement at an ongoing maintenance session in months 19-21	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
G9885	Two Medicare Diabetes Prevention Program (MDPP) ongoing maintenance sessions (MS) were attended by an MDPP beneficiary in months (mo) 22-24 under the MDPP Expanded Model (EM). An ongoing maintenance session is an MDPP service that: (1) is furnished by an MDPP supplier during months 13 through 24 of the MDPP services period; (2) is approximately 1 hour in length; and (3) adheres to a CDC-approved DPP curriculum for maintenance sessions. The beneficiary maintained at least 5% weight loss (WL) from his/her baseline weight, as measured by at least one in-person weight measurement at an ongoing maintenance session in months 22-24	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.

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Code List

Code	Description	Plan Review Requirement	Reviewed For	Records Request
G9886	Behavioral counseling for diabetes prevention, in-person, group, 60 minutes	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
G9887	Behavioral counseling for diabetes prevention, distance learning, 60 minutes	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
G9888	Maintenance 5% WL from baseline weight in months 7-12	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
G9890	Bridge Payment: A one-time payment for the first Medicare Diabetes Prevention Program (MDPP) core session, core maintenance session, or ongoing maintenance session furnished by an MDPP supplier to an MDPP beneficiary during months 1-24 of the MDPP Expanded Model (EM) who has previously received MDPP services from a different MDPP supplier under the MDPP Expanded Model. A supplier may only receive one bridge payment per MDPP beneficiary	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
G9891	MDPP session reported as a line-item on a claim for a payable MDPP Expanded Model (EM) HCPCS code for a session furnished by the billing supplier under the MDPP Expanded Model and counting toward achievement of the attendance performance goal for the payable MDPP Expanded Model HCPCS code. (This code is for reporting purposes only)	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.

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Code List

Code	Description	Plan Review Requirement	Reviewed For	Records Request
G9978	Remote in-home visit for the evaluation and management of a new patient for use only in a Medicare-approved Bundled Payments for Care Improvement Advanced (BPCI Advanced) model episode of care, which requires these three key components: a problem focused history; a problem focused examination; straightforward medical decision making, furnished in real time using interactive audio and video technology. Counseling and coordination of care with other physicians, other qualified health care professionals or agencies are provided consistent with the nature of the problem(s) and the needs of the patient or the family or both. Usually, the presenting problem(s) are self limited or minor. Typically, 10 minutes are spent with the patient or family or both via real time, audio and video intercommunications technology	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.

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Code List

Code	Description	Plan Review Requirement	Reviewed For	Records Request
G9979	Remote in-home visit for the evaluation and management of a new patient for use only in a Medicare-approved Bundled Payments for Care Improvement Advanced (BPCI Advanced) model episode of care, which requires these three key components: an expanded problem focused history; an expanded problem focused examination; straightforward medical decision making, furnished in real time using interactive audio and video technology. Counseling and coordination of care with other physicians, other qualified health care professionals or agencies are provided consistent with the nature of the problem(s) and the needs of the patient or the family or both. Usually, the presenting problem(s) are of low to moderate severity. Typically, 20 minutes are spent with the patient or family or both via real time, audio and video intercommunications technology	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.

To search: Use CTRL+F for PCs or Command+F for Macs, and type in the code.
If no results are found, the code doesn't require review related to a medical policy.
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Code List

Code	Description	Plan Review Requirement	Reviewed For	Records Request
G9980	Remote in-home visit for the evaluation and management of a new patient for use only in a Medicare-approved Bundled Payments for Care Improvement Advanced (BPCI Advanced) model episode of care, which requires these three key components: a detailed history; a detailed examination; medical decision making of low complexity, furnished in real time using interactive audio and video technology. Counseling and coordination of care with other physicians, other qualified health care professionals or agencies are provided consistent with the nature of the problem(s) and the needs of the patient or the family or both. Usually, the presenting problem(s) are of moderate severity. Typically, 30 minutes are spent with the patient or family or both via real time, audio and video intercommunications technology	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.

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Code List

Code	Description	Plan Review Requirement	Reviewed For	Records Request
G9981	Remote in-home visit for the evaluation and management of a new patient for use only in a Medicare-approved Bundled Payments for Care Improvement Advanced (BPCI Advanced) model episode of care, which requires these three key components: a comprehensive history; a comprehensive examination; medical decision making of moderate complexity, furnished in real time using interactive audio and video technology. Counseling and coordination of care with other physicians, other qualified health care professionals or agencies are provided consistent with the nature of the problem(s) and the needs of the patient or the family or both. Usually, the presenting problem(s) are of moderate to high severity. Typically, 45 minutes are spent with the patient or family or both via real time, audio and video intercommunications technology	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.

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Code List

Code	Description	Plan Review Requirement	Reviewed For	Records Request
G9982	Remote in-home visit for the evaluation and management of a new patient for use only in a Medicare-approved Bundled Payments for Care Improvement Advanced (BPCI Advanced) model episode of care, which requires these three key components: a comprehensive history; a comprehensive examination; medical decision making of high complexity, furnished in real time using interactive audio and video technology. Counseling and coordination of care with other physicians, other qualified health care professionals or agencies are provided consistent with the nature of the problem(s) and the needs of the patient or the family or both. Usually, the presenting problem(s) are of moderate to high severity. Typically, 60 minutes are spent with the patient or family or both via real time, audio and video intercommunications technology	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.

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Code List

Code	Description	Plan Review Requirement	Reviewed For	Records Request
G9983	Remote in-home visit for the evaluation and management of an established patient for use only in a Medicare-approved Bundled Payments for Care Improvement Advanced (BPCI Advanced) model episode of care, which requires at least two of the following three key components: a problem focused history; a problem focused examination; straightforward medical decision making, furnished in real time using interactive audio and video technology. Counseling and coordination of care with other physicians, other qualified health care professionals or agencies are provided consistent with the nature of the problem(s) and the needs of the patient or the family or both. Usually, the presenting problem(s) are self limited or minor. Typically, 10 minutes are spent with the patient or family or both via real time, audio and video intercommunications technology	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.

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Code List

Code	Description	Plan Review Requirement	Reviewed For	Records Request
G9984	Remote in-home visit for the evaluation and management of an established patient for use only in a Medicare-approved Bundled Payments for Care Improvement Advanced (BPCI Advanced) model episode of care, which requires at least two of the following three key components: an expanded problem focused history; an expanded problem focused examination; medical decision making of low complexity, furnished in real time using interactive audio and video technology. Counseling and coordination of care with other physicians, other qualified health care professionals or agencies are provided consistent with the nature of the problem(s) and the needs of the patient or the family or both. Usually, the presenting problem(s) are of low to moderate severity. Typically, 15 minutes are spent with the patient or family or both via real time, audio and video intercommunications technology	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.

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G9985	Remote in-home visit for the evaluation and management of an established patient for use only in a Medicare-approved Bundled Payments for Care Improvement Advanced (BPCI Advanced) model episode of care, which requires at least two of the following three key components: a detailed history; a detailed examination; medical decision making of moderate complexity, furnished in real time using interactive audio and video technology. Counseling and coordination of care with other physicians, other qualified health care professionals or agencies are provided consistent with the nature of the problem(s) and the needs of the patient or the family or both. Usually, the presenting problem(s) are of moderate to high severity. Typically, 25 minutes are spent with the patient or family or both via real time, audio and video intercommunications technology	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.

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Code List

Code	Description	Plan Review Requirement	Reviewed For	Records Request
G9986	Remote in-home visit for the evaluation and management of an established patient for use only in a Medicare-approved Bundled Payments for Care Improvement Advanced (BPCI Advanced) model episode of care, which requires at least two of the following three key components: a comprehensive history; a comprehensive examination; medical decision making of high complexity, furnished in real time using interactive audio and video technology. Counseling and coordination of care with other physicians, other qualified health care professionals or agencies are provided consistent with the nature of the problem(s) and the needs of the patient or the family or both. Usually, the presenting problem(s) are of moderate to high severity. Typically, 40 minutes are spent with the patient or family or both via real time, audio and video intercommunications technology	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.

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Code List

Code	Description	Plan Review Requirement	Reviewed For	Records Request
G9987	Bundled Payments for Care Improvement Advanced (BPCI Advanced) model home visit for patient assessment performed by clinical staff for an individual not considered homebound, including, but not necessarily limited to patient assessment of clinical status, safety/fall prevention, functional status/ambulation, medication reconciliation/management, compliance with orders/plan of care, performance of activities of daily living, and ensuring beneficiary connections to community and other services; for use only for a BPCI Advanced model episode of care; may not be billed for a 30-day period covered by a transitional care management code	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
H0006	Alcohol and/or drug services; case management	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
H0021	Alcohol and/or drug training service (for staff and personnel not employed by providers)	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
H0023	Behavioral health outreach service (planned approach to reach a targeted population)	Non-covered Service	Not Covered	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	Not Covered	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	Not Covered	Considered non-covered unless member's contract indicates coverage.

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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	Not Covered	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	Not Covered	Considered non-covered unless member's contract indicates coverage.
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	Not Covered	Considered non-covered unless member's contract indicates coverage.
H0030	Behavioral health hotline service	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
H0036	Community psychiatric supportive treatment, face-to-face, per 15 minutes	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
H0037	Community psychiatric supportive treatment program, per diem	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
H0038	Self-help/peer services, per 15 minutes	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
H0039	Assertive community treatment, face-to-face, per 15 minutes	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
H0040	Assertive community treatment program, per diem	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
H0041	Foster care, child, nontherapeutic, per diem	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
H0042	Foster care, child, nontherapeutic, per month	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
H0043	Supported housing, per diem	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
H0044	Supported housing, per month	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.

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H0045	Respite care services, not in the home, per diem	Non-covered Service	Not Covered	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	History and physical, documentation of medical necessity, and procedure report
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	History and physical, documentation of medical necessity and description of services performed
H0049	Alcohol and/or drug screening	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
H0051	Traditional healing service	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
H1011	Family assessment by licensed behavioral health professional for state defined purposes	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
H2014	Skills training and development, per 15 minutes	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
H2015	Comprehensive community support services, per 15 minutes	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
H2016	Comprehensive community support services, per diem	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
H2021	Community-based wrap-around services, per 15 minutes	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
H2022	Community-based wrap-around services, per diem	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
H2024	Supported employment, per diem	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
H2025	Ongoing support to maintain employment, per 15 minutes	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
H2026	Ongoing support to maintain employment, per diem	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
H2027	Psychoeducational service, per 15 minutes	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
H2028	Sexual offender treatment service, per 15 minutes	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.

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H2029	Sexual offender treatment services per diem	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
H2030	Mental health clubhouse services, per 15 minutes	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
H2031	Mental health clubhouse services, per diem	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
H2033	Multisystemic therapy for juveniles, per 15 minutes	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
H2034	Alcohol and/or drug abuse halfway house services, per diem	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
H2037	Developmental delay prevention activities, dependent child of client, per 15 minutes	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
H2038	Skills training and development, per diem	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
J0013	Esketamine, nasal spary (Spravato), 1 mg	Prior Authorization Required	Medical Necessity	History and Physical, clinical notes related to a condition being treated, documentation of previous therapies tried and failed.
J0121	Injection, omadacycline, 1 mg	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and Physical, documentation of medical necessity
J0129	Injection, abatacept, 10 mg	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical demonstrating reason for requested medication, lab work (if applicable), dosage and duration of treatment, office notes related to condition, documentation of medical necessity, and documentation of previous therapies/treatments tried
J0139	Injection, adalimumab, 1 mg	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and Physical, clinical notes related to a condition being treated, documentation of previous therapies tried and failed.
J0175	Injection, donanemab-azbt, 2 mg	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history and physical, documentation of medical necessity.
J0177	Injection, aflibercept HD, 1 mg	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and Physical, documentation of medical necessity

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J0178	Injection, aflibercept, 1 mg (Eylea)	Prior Authorization Required	Medical Necessity	History and physical, and clinical notes of condition being treated, including documentation of previous therapies tried and failed, and proposed treatment plan
J0179	Injection, brolucizumab-dbll, 1 mg	Prior Authorization Required	Medical Necessity	History and physical, and clinical notes of condition being treated, including documentation of previous therapies tried and failed, and proposed treatment plan
J0180	Injection, agalsidase beta, 1 mg	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history and physical, documentation of medical necessity.
J0184	Injection, amisulpride, 1 mg	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history and physical, documentation of medical necessity.
J0202	Injection, Alemtuzumab, 1 MG	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, documentation of medical necessity, treatment plan
J0217	Injection, velmanase alfa-tycv, 1 mg	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history and physical, documentation of medical necessity.
J0218	Injection, Olipudase alfa-rpcp, 1 mg	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and Physical, documentation of medical necessity
J0219	Injection, avalglucosidase alfa-ngpt, 4 mg	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and Physical, documentation of medical necessity
J0220	Injection, alglucosidase alfa, 10 mg, not otherwise specified	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history and physical, documentation of medical necessity.
J0221	Injection, alglucosidase alfa, (Lumizyme), 10 mg	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and Physical, documentation of medical necessity
J0222	Injection, patisiran, 0.1 mg	Prior Authorization Required	Medical Necessity	History and physical, and clinical notes of condition being treated, including documentation of previous therapies tried and failed, and proposed treatment plan
J0223	Injection, givosiran, 0.5 mg	Prior Authorization Required	Medical Necessity	History and physical, and clinical notes of condition being treated, including documentation of previous therapies tried and failed, and proposed treatment plan

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J0224	Injection, lumasiran, 0.5 mg	Prior Authorization Required	Medical Necessity	History and physical, and clinical notes of condition being treated, including documentation of previous therapies tried and failed, and proposed treatment plan
J0225	Injection, vutrisiran, 1 mg	Prior Authorization Required	Medical Necessity	History and physical, and clinical notes of condition being treated, including documentation of previous therapies tried and failed, and proposed treatment plan
J0256	Injection, alpha 1 proteinase inhibitor (human), not otherwise specified, 10 mg	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and Physical, documentation of medical necessity
J0257	Injection, alpha 1 proteinase inhibitor (human), (GLASSIA), 10 mg	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and Physical, documentation of medical necessity
J0364	Injection, apomorphine HCl, 1 mg	Advance Benefit Determination (ABD) recommended	Medical Necessity	Direct providers and members to the Specialty Pharmacy Program at 888-346-3731 or visit the Pharmacy section on www.fepblue.org
J0490	Injection, belimumab, 10 mg	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, documentation of medical necessity, treatment plan
J0491	Injection, anifrolumab-fnia, 1 mg	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and Physical, documentation of medical necessity
J0517	Injection, benralizumab, 1 mg	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and Physical, documentation of medical necessity
J0567	Injection, cerliponase alfa, 1 mg	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, documentation of medical necessity, treatment plan
J0584	Injection, burosumab-twza 1 mg	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and Physical, documentation of medical necessity
J0585	Injection, onabotulinumtoxinA, 1 unit	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical indicating medical necessity. Documentation of previous therapies/treatments tried and results of the treatments

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J0586	Injection, abobotulinumtoxinA, 5 units	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical demonstrating reason for requested medication, lab work (if applicable), dosage and duration of treatment, office notes related to condition, documentation of medical necessity, and documentation of previous therapies/treatments tried
J0587	Injection, rimabotulinumtoxinB, 100 units	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical demonstrating reason for requested medication, lab work (if applicable), dosage and duration of treatment, office notes related to condition, documentation of medical necessity, and documentation of previous therapies/treatments tried
J0588	Injection, incobotulinumtoxinA, 1 unit	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical demonstrating reason for requested medication, lab work (if applicable), dosage and duration of treatment, office notes related to condition, documentation of medical necessity, and documentation of previous therapies/treatments tried
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)	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and Physical, documentation of medical necessity
J0596	Injection, C1 esterase inhibitor (recombinant), Ruconest, 10 units	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and Physical, documentation of medical necessity
J0597	Injection, C-1 esterase inhibitor (human), Berinert, 10 units	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history and physical, documentation of medical necessity.
J0598	Injection, C-1 esterase inhibitor (human), Cinryze, 10 units	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and Physical, documentation of medical necessity
J0599	Injection, C-1 esterase inhibitor (human), (Haegarda), 10 units	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and Physical, documentation of medical necessity
J0638	Injection, canakinumab, 1 mg	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history and physical, documentation of medical necessity.

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J0691	Injection, lefamulin, 1 mg	Advance Benefit Determination (ABD) recommended	Medical Necessity	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)	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and Physical, clinical notes related to the condition being treated, documentation of previous therapies tried and failed.
J0725	Injection, chorionic gonadotropin, per 1,000 USP units	Prior Authorization Required	Medical Necessity	History and physical, documentation of infertility, including treatment plan
J0739	Injection, cabotegravir, 1 mg	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history and physical, documentation of medical necessity.
J0741	Injection, cabotegravir and rilpivirine, 2 mg/3 mg	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history and physical, documentation of medical necessity.
J0775	Injection, collagenase, clostridium histolyticum, 0.01 mg	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history and physical, documentation of medical necessity.
J0791	Injection, crizanlizumab-tmca, 5 mg	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history and physical, documentation of medical necessity.
J0801	Injection, corticotropin (acthar gel), up to 40 units	Advance Benefit Determination (ABD) recommended	Medical Necessity	Direct providers and members to the Specialty Pharmacy Program at 888-346-3731 or visit the Pharmacy section on www.fepblue.org
J0802	Injection, corticotropin (ani), up to 40 units	Advance Benefit Determination (ABD) recommended	Medical Necessity	Direct providers and members to the Specialty Pharmacy Program at 888-346-3731 or visit the Pharmacy section on www.fepblue.org
J0870	Injection, imetelstat, 1 mg	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and Physical, clinical notes related to a condition being treated, documentation of previous therapies tried and failed.
J0879	Injection, difelikefalin, 0.1 microgram, (for ESRD on dialysis)	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and Physical, documentation of medical necessity
J0881	Injection, darbepoetin alfa, 1 mcg (non-ESRD use)	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, including recent lab work and any other attempted medications and response(s), if applicable

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J0882	Injection, darbepoetin alfa, 1 mcg (for ESRD on dialysis)	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical from ordering physician, with Hgb level and transferrin saturation or ferritin level within 1 month of starting erythropoietin stimulating agent (i.e., Epogen, Aranesp, Procrit) and monthly for ongoing treatment; allow for those under age 18.
J0885	Injection, epoetin alfa, (for non-ESRD use), 1000 units	Prior Authorization Required	Medical Necessity	History and physical with hemoglobin level and transferrin saturation or ferritin level within one month of starting treatment, and documentation of previous erythropoietin stimulating agent(s) tried and failed, and proposed treatment plan
J0887	Injection, epoetin beta, 1 microgram, (for ESRD on dialysis)	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history and physical from ordering physician and most recent Hgb level and transferrin saturation or ferritin level.
J0888	Injection, epoetin beta, 1 microgram, (for non-ESRD use)	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history and physical from ordering physician and most recent Hgb level and transferrin saturation or ferritin level.
J0896	Injection, luspatercept-aamt, 0.25 mg	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and Physical, documentation of medical necessity
J0897	Injection, denosumab, 1 mg	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, including recent lab work and any other attempted medications and response(s), if applicable

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J1071	Injection, testosterone cypionate, 1 mg	Advance Benefit Determination (ABD) recommended	Medical Necessity	For males <18 years: Submit history and physical confirming diagnosis of delay in sexual development and/or puberty; bone age to be assessed, including liver function tests, and hematocrit levels; for males 18 and older: Submit history and physical and baseline with annual PSA for patients over age 40 (prostatectomy excluded from the requirement). For males or females: Monitor heart attack, stroke, and cancer risks, as well as regular monitoring of liver function tests, and hematocrit levels
J1072	Injection, testosterone cypionate (Azmiro), 1 mg	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and Physical, documentation of medical necessity
J1201	Injection, cetirizine HCl, 0.5 mg	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and Physical, documentation of medical necessity
J1203	Injection, cipaglucosidase alfa-atga, 5 mg	Prior Authorization Required	Medical Necessity	History and Physical, documentation of medical necessity
J1290	Injection, ecallantide, 1 mg	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history and physical, documentation of medical necessity.
J1299	Injection, eculizumab, 2 mg	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity and previously tried therapies
J1301	Injection, edaravone, 1 mg	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and Physical, documentation of medical necessity
J1302	Injection, sutimlimab-jome, 10 mg	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and Physical, documentation of medical necessity
J1303	Injection, ravulizumab-cwvz, 10 mg	Prior Authorization Required	Medical Necessity	History and physical, and clinical notes of condition being treated, including documentation of previous therapies tried and failed, and proposed treatment plan
J1304	Injection, tofersen, 1 mg	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history and physical, documentation of medical necessity.

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J1305	Injection, evinacumab-dgnb, 5 mg	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and Physical, documentation of medical necessity
J1306	Injection, inclisiran, 1 mg	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and Physical, documentation of medical necessity
J1322	Injection, elosulfase alfa, 1 mg	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history and physical, documentation of medical necessity.
J1323	Injection, elranatamab-bcmm, 1 mg	Prior Authorization Required	Medical Necessity	History and Physical, documentation of medical necessity
J1324	Injection, enfuvirtide, 1 mg	Advance Benefit Determination (ABD) recommended	Medical Necessity	Benefits for this drug are limited to once per lifetime when provided by a physician, health care professional or hospital. Please direct providers and members to the Specialty Pharmacy Program at 888-346-3731 or visit the Pharmacy section on www.fepblue.org
J1325	Injection, epoprostenol, 0.5 mg	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical demonstrating reason for requested medication, lab work (if applicable), dosage and duration of treatment, office notes related to condition, documentation of medical necessity, and documentation of previous therapies/treatments tried
J1326	Injection, zolbetuximab-clzb, 2 mg	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and Physical, documentation of medical necessity
J1411	Injection, etranacogene dezaparvovec-drlb, per therapeutic dose	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, and treatment plan
J1412	Injection, valoctocogene roxaparvovec-rvox, per ml, containing nominal 2x10^13 vector genomes	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history and physical, documentation of medical necessity.
J1413	Injection, delandistrogene moxeparvovec-rokl, per therapeutic dose	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, and treatment plan
J1426	Injection, casimersen, 10 mg	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and Physical, documentation of medical necessity
J1427	Injection, Viltolarsen, 10mg	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and Physical, documentation of medical necessity
J1428	Injection, eteplirsen, 10 mg	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, documentation of medical necessity, treatment plan

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
J1429	Injection, golodirsen, 10 mg	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and Physical, documentation of medical necessity
J1437	Injection, ferric derisomaltose, 10 mg	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and Physical, clinical notes related to a condition being treated, documentation of previous therapies tried and failed.
J1438	Injection Etanercept (Enbrel) 25 MG	Advance Benefit Determination (ABD) recommended	Medical Necessity	Direct providers and members to the Specialty Pharmacy Program at 888-346-3731 or visit the Pharmacy section on www.fepblue.org
J1439	Injection, ferric carboxymaltose, 1 mg	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and Physical, clinical notes related to a condition being treated, documentation of previous therapies tried and failed.
J1442	Injection, filgrastim (G-CSF), excludes biosimilars, 1 microgram	Prior Authorization Required	Medical Necessity	History and physical, and clinical notes of condition being treated, including documentation of previous therapies tried and failed, and proposed treatment plan
J1447	Injection, tbo-filgrastim, 1 mcg	Prior Authorization Required	Medical Necessity	History and physical, and clinical notes of condition being treated, including documentation of previous therapies tried and failed, and proposed treatment plan
J1448	Injection, trilaciclib, 1 mg	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and Physical, documentation of medical necessity
J1449	Injection, eflapegrastim-xnst, 0.1 mg	Prior Authorization Required	Medical Necessity	History and physical, and clinical notes of condition being treated, including documentation of previous therapies tried and failed, and proposed treatment plan
J1458	Injection, galsulfase, 1 mg	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history and physical, documentation of medical necessity.

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Code List

Code	Description	Plan Review Requirement	Reviewed For	Records Request
J1459	Injection, immune globulin (Privigen), intravenous, nonlyophilized (e.g., liquid), 500 mg	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, including recent lab work and any other attempted medications and response(s), if applicable
J1551	Injection, immune globulin (Cutaquig), 100 mg	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, including recent lab work and any other attempted medications and response(s), if applicable
J1552	Injection, immune globulin (alyglo), 500 mg	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history, physical, lab report and documentation of medical necessity
J1552	Injection, immune globulin (alyglo), 500 mg	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, including recent lab work and any other attempted medications and response(s), if applicable
J1554	Injection, immune globulin (asceniv), 500 mg	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, including recent lab work and any other attempted medications and response(s), if applicable
J1555	Injection, immune globulin (Cuvitru), 100 mg	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history, physical, lab report and documentation of medical necessity
J1555	Injection, immune globulin (Cuvitru), 100 mg	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, including recent lab work and any other attempted medications and response(s), if applicable
J1556	Injection, immune globulin (bivigam), 500 mg	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, including recent lab work and any other attempted medications and response(s), if applicable

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
J1557	Injection, immune globulin, (Gammaplex), intravenous, nonlyophilized (e.g., liquid), 500 mg	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history, physical, lab report and documentation of medical necessity
J1557	Injection, immune globulin, (Gammaplex), intravenous, nonlyophilized (e.g., liquid), 500 mg	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, including recent lab work and any other attempted medications and response(s), if applicable
J1558	Injection, immune globulin (xembify), 100 mg	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history, physical, lab report and documentation of medical necessity
J1558	Injection, immune globulin (xembify), 100 mg	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, including recent lab work and any other attempted medications and response(s), if applicable
J1559	Injection, immune globulin (Hizentra), 100 mg	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history, physical, lab report and documentation of medical necessity
J1559	Injection, immune globulin (Hizentra), 100 mg	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, including recent lab work and any other attempted medications and response(s), if applicable
J1560	Injection, gamma globulin, intramuscular, over 10 cc	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history and physical, documentation of medical necessity.
J1560	Injection, gamma globulin, intramuscular, over 10 cc	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, including recent lab work and any other attempted medications and response(s), if applicable
J1561	Injection, immune globulin, (Gamunex), intravenous, nonlyophilized (e.g., liquid), 500 mg	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history, physical, lab report and documentation of medical necessity

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J1561	Injection, immune globulin, (Gamunex), intravenous, nonlyophilized (e.g., liquid), 500 mg	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, including recent lab work and any other attempted medications and response(s), if applicable
J1562	Injection, immune globulin (Vivaglobin), 100 mg	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history, physical, lab report and documentation of medical necessity
J1566	Injection, immune globulin, intravenous, lyophilized (e.g., powder), not otherwise specified, 500 mg	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history, physical, lab report and documentation of medical necessity
J1566	Injection, immune globulin, intravenous, lyophilized (e.g., powder), not otherwise specified, 500 mg	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, including recent lab work and any other attempted medications and response(s), if applicable
J1568	Injection, immune globulin, (Octagam), intravenous, nonlyophilized (e.g., liquid), 500 mg	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history, physical, lab report and documentation of medical necessity
J1568	Injection, immune globulin, (Octagam), intravenous, nonlyophilized (e.g., liquid), 500 mg	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, including recent lab work and any other attempted medications and response(s), if applicable
J1569	Injection, immune globulin, (Gammagard liquid) nonlyophilized, (e.g., liquid), 500 mg	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, including recent lab work and any other attempted medications and response(s), if applicable
J1575	Injection, immune globulin/Hyaluronidase, (HYQVIA), 100 MG immune globulin	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history, physical, lab report and documentation of medical necessity
J1575	Injection, immune globulin/Hyaluronidase, (HYQVIA), 100 MG immune globulin	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, including recent lab work and any other attempted medications and response(s), if applicable

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J1576	Injection, immune globulin (panzyga), intravenous, non-lyophilized (e.g., liquid), 500 mg	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history, physical, lab report and documentation of medical necessity
J1576	Injection, immune globulin (panzyga), intravenous, non-lyophilized (e.g., liquid), 500 mg	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, including recent lab work and any other attempted medications and response(s), if applicable
J1595	Injection, glatiramer acetate, 20 mg	Advance Benefit Determination (ABD) recommended	Medical Necessity	Benefits for this drug are limited to once per lifetime when provided by a physician, health care professional or hospital. Please direct providers and members to the Specialty Pharmacy Program at 888-346-3731 or visit the Pharmacy section on www.fepblue.org
J1599	Injection, immune globulin, intravenous, nonlyophilized (e.g., liquid), not otherwise specified, 500 mg	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history, physical, lab report and documentation of medical necessity
J1602	Injection, golimumab, 1 mg, for intravenous use	Prior Authorization Required	Medical Necessity	History and physical, and clinical notes of condition being treated, including documentation of previous therapies tried and failed, and proposed treatment plan
J1628	Injection, guselkumab, 1 mg	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and Physical, documentation of medical necessity
J1632	Injection, brexanolone, 1 mg	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, documentation of medical necessity, treatment plan
J1675	Injection, histrelin acetate, 10 mcg	Prior Authorization Required	Medical Necessity	Submit History and physical, documentation of infertility, treatment plan. NOTE: Prior Authorization required if it is related to infertility
J1743	Injection, idursulfase, 1 mg	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history and physical, documentation of medical necessity.
J1744	Injection, icatibant, 1 mg	Advance Benefit Determination (ABD) recommended	Medical Necessity	Direct providers and members to the Specialty Pharmacy Program at 888-346-3731 or visit the Pharmacy section on www.fepblue.org

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J1745	Injection, infliximab, excludes biosimilar, 10 mg	Prior Authorization Required	Medical Necessity	History and physical, and clinical notes of condition being treated, including documentation of previous therapies tried and failed, and proposed treatment plan
J1746	Injection, ibalizumab-uiyk, 10 mg	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and Physical, documentation of medical necessity
J1748	Injection, infliximab-dyyb (Zymfentra), 10 mg	Prior Authorization Required	Medical Necessity	History and Physical, documentation of medical necessity
J1786	Injection, imiglucerase, 10 units	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history and physical, documentation of medical necessity.
J1823	Injection, inebilizumab-cdon, 1 mg	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history and physical, documentation of medical necessity.
J1826	Injection, interferon beta-1a, 30 mcg	Advance Benefit Determination (ABD) recommended	Medical Necessity	Benefits for this drug are limited to once per lifetime when provided by a physician, health care professional or hospital. Please direct providers and members to the Specialty Pharmacy Program at 888-346-3731 or visit the Pharmacy section on www.fepblue.org
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)	Advance Benefit Determination (ABD) recommended	Medical Necessity	Benefits for this drug are limited to once per lifetime when provided by a physician, health care professional or hospital. Please direct providers and members to the Specialty Pharmacy Program at 888-346-3731 or visit the Pharmacy section on www.fepblue.org
J1833	Injection, isavuconazonium, 1 mg	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history and physical, documentation of medical necessity.
J1835	Injection, itraconazole, 50 mg	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history and physical, documentation of medical necessity.
J1930	Injection, lanreotide, 1 mg	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and Physical, documentation of medical necessity
J1931	Injection, laronidase, 0.1 mg	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history and physical, documentation of medical necessity.
J1932	Injection, lanreotide, (Cipla), 1 mg	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and Physical, documentation of medical necessity

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J1941	Injection, furosemide (Furoscix), 20 mg	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and Physical, documentation of medical necessity
J1950	Injection, leuprolide acetate (for depot suspension), per 3.75 mg	Prior Authorization Required	Medical Necessity	For infertility treatment, submit history and physical, and documentation of infertility and treatment plan; for non-fertility related treatment, submit a history and physical, and documentation of medical necessity
J1951	Injection, leuprolide acetate for depot suspension (fensolvi), 0.25 mg	Prior Authorization Required	Medical Necessity	For infertility treatment, submit history and physical, and documentation of infertility and treatment plan; for non-fertility related treatment, submit a history and physical, and documentation of medical necessity
J1952	Leuprolide injectable, camcevi, 1 mg	Prior Authorization Required	Medical Necessity	For infertility treatment, submit history and physical, and documentation of infertility and treatment plan; for non-fertility related treatment, submit a history and physical, and documentation of medical necessity
J1961	Injection, lenacapavir (only for use as HIV treatement), 1 mg	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history and physical, documentation of medical necessity.
J2020	Injection, linezolid, 200 mg	Advance Benefit Determination (ABD) recommended	Medical Necessity	Please provide from the ordering physician the history and physical and the clinical notes for medical necessity for J2020.
J2021	Injection, linezolid (Hospira) not therapeutically equivalent to J2020, 200 mg	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and Physical, documentation of medical necessity
J2170	Injection, mecasermin, 1 mg	Advance Benefit Determination (ABD) recommended	Medical Necessity	Direct providers and members to the Specialty Pharmacy Program at 888-346-3731 or visit the Pharmacy section on www.fepblue.org
J2182	Injection, Mepolizumab, 1 MG	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and Physical, clinical notes from ordering provider, treatment plan

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J2212	Injection, methylnaltrexone, 0.1 mg	Advance Benefit Determination (ABD) recommended	Medical Necessity	Please submit the history and physical, the clinical notes of inadequate response to laxative therapy, absence of gastrointestinal and hepatic treatment, and notes for medical necessity for J2212.
J2267	Injection, mirikizumab-mrkz, 1 mg	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history and physical from ordering physician and most recent Hgb level and transferrin saturation or ferritin level.
J2277	Injection, motixafortide, 0.25 mg	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and Physical, documentation of medical necessity
J2310	Injection, naloxone HCl, per 1 mg	Advance Benefit Determination (ABD) recommended	Medical Necessity	Allow with outpatient and inpatient facility claims per instruction from IHM
J2323	Injection, natalizumab, 1 mg	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and Physical, including prior treatments and response, and evidence that member is enrolled in and meets all conditions of the TOUCH Prescribing Program.
J2323	Injection, natalizumab, 1 mg	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, including recent lab work and any other attempted medications and response(s), if applicable
J2326	Injection, nusinersen, 0.1 mg	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, documentation of medical necessity, treatment plan
J2326	Injection, nusinersen, 0.1 mg	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, including recent lab work and any other attempted medications and response(s), if applicable
J2327	Injection, risankizumab-rzaa, intravenous, 1 mg	Prior Authorization Required	Medical Necessity	History and physical, and clinical notes of condition being treated, including documentation of previous therapies tried and failed, and proposed treatment plan

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J2329	Injection, ublituximab-xiiy, 1mg	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, including recent lab work and any other attempted medications and response(s), if applicable
J2350	Injection, ocrelizumab, 1 mg	Prior Authorization Required	Medical Necessity	History and physical, and clinical notes of condition being treated, including documentation of previous therapies tried and failed, and proposed treatment plan
J2351	Injection, ocrelizumab, 1 mg and hyaluronidase-ocsq	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history and physical from ordering physician, with Hgb level and transferrin saturation or ferritin level within 1 month of starting treatment, documentation of previous erythropoietin stimulating agent tried and failed.
J2353	Injection, octreotide, depot form for intramuscular injection, 1 mg	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and Physical, clinical notes from ordering provider, treatment plan
J2354	Injection, octreotide, nondepot form for subcutaneous or intravenous injection, 25 mcg	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and Physical, clinical notes from ordering provider, treatment plan
J2356	Injection, tezepelumab-ekko, 1 mg	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and Physical, documentation of medical necessity
J2357	Injection, omalizumab, 5 mg	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical demonstrating reason for requested medication, lab work (if applicable), dosage and duration of treatment, office notes related to condition, documentation of medical necessity, and documentation of previous therapies/treatments tried
J2358	Injection, olanzapine, long-acting, 1 mg	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and Physical, documentation of medical necessity and evidence that patient, prescriber and healthcare facility are enrolled in the Zyprexa Relprevv Patient Care Program

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J2359	Injection, olanzapine, 0.5 mg	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and Physical, documentation of medical necessity
J2425	Injection, palifermin, 50 mcg	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history and physical, documentation of medical necessity.
J2440	PAVABID TO 60 MG	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history and physical, documentation of medical necessity.
J2470	Injection, pantoprazole sodium, 40 mg	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and Physical, procedure report.
J2471	Injection, pantoprazole (hikma), not therapeutically equivalent to J2470, 40 mg	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and Physical, procedure report.
J2502	Injection, Pasireotide Long Acting, 1 MG	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history and physical, documentation of medical necessity and procedure report.
J2506	Injection, pegfilgrastim, excludes biosimilar, 0.5 mg	Prior Authorization Required	Medical Necessity	History and physical, and clinical notes of condition being treated, including documentation of previous therapies tried and failed, and proposed treatment plan
J2507	Injection, pegloticase, 1 mg	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history and physical, documentation of medical necessity.
J2508	Injection, pegunigalsidase alfa-iwxj, 1 mg	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history and physical, documentation of medical necessity.
J2562	Injection, plerixafor, 1 mg	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and Physical, documentation of medical necessity
J2675	Injection, progesterone, per 50 mg	Prior Authorization Required	Medical Necessity	For infertility treatment, submit history and physical, and documentation of infertility and treatment plan; for non-fertility related treatment, submit a history and physical, and documentation of medical necessity
J2760	Injection, phentolamine mesylate, up to 5 mg	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history and physical, documentation of medical necessity.

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J2777	Injection, faricimab-svoa, 0.1 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, documentation of medical necessity, and documentation of previous therapies/treatments tried
J2778	Injection, ranibizumab, 0.1 mg	Prior Authorization Required	Medical Necessity	History and physical, and clinical notes of condition being treated, including documentation of previous therapies tried and failed, and proposed treatment plan
J2779	Injection, ranibizumab, via intravitreal implant (Susvimo), 0.1 mg	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and Physical, documentation of medical necessity
J2781	Injection, Pegcetacoplan, intravitreal, 1 mg	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and Physical, documentation of medical necessity
J2782	Injection, avacincaptad pegol, 0.1 mg	Prior Authorization Required	Medical Necessity	History and Physical, documentation of medical necessity
J2786	Injection, reslizumab, 1 mg	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and Physical, clinical notes from ordering provider, treatment plan
J2793	Injection, rilonacept, 1 mg	Advance Benefit Determination (ABD) recommended	Medical Necessity	Direct providers and members to the Specialty Pharmacy Program at 888-346-3731 or visit the Pharmacy section on www.fepblue.org
J2802	Injection, romiplostim, 1 microgram	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history and physical, documentation of medical necessity.
J2820	Injection, sargramostim (GM-CSF), 50 mcg	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history and physical, documentation of medical necessity.
J2840	Injection, sebelipase alfa, 1 mg	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and Physical, clinical notes from ordering provider, treatment plan
J2860	Injection, siltuximab, 10 mg	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and Physical, clinical notes from ordering provider, treatment plan
J2941	Injection, somatropin, 1 mg	Advance Benefit Determination (ABD) recommended	Medical Necessity	Direct providers and members to the Specialty Pharmacy Program at 888-346-3731 or visit the Pharmacy section on www.fepblue.org

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J2998	Injection, plasminogen, human-tvmh, 1 mg	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and Physical, documentation of medical necessity
J3030	Injection, sumatriptan succinate, 6 mg	Advance Benefit Determination (ABD) recommended	Medical Necessity	Allow J3030 per instruction from IHM for members 6 years of age or older.For members less than 6 years of age, Please submit history and physical and clinical notes for 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)	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and Physical, documentation of medical necessity
J3032	Injection, eptinezumab-jjmr, 1 mg	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and Physical, documentation of medical necessity including previous treatments tried.
J3055	Injection, talquetamab-tgvs, 0.25 mg	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history and physical, documentation of medical necessity.
J3060	Injection, taliglucerase alfa, 10 units	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history and physical, documentation of medical necessity.
J3090	Injection, tedizolid phosphate, 1 mg	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history and physical, documentation of medical necessity.
J3105	Injection, terbutaline sulfate, up to 1 mg	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history and physical, documentation of medical necessity.
J3110	Injection, teriparatide, 10 mcg	Advance Benefit Determination (ABD) recommended	Medical Necessity	Direct providers and members to the Specialty Pharmacy Program at 888-346-3731 or visit the Pharmacy section on www.fepblue.org
J3111	Injection, romosozumab-aqqg, 1 mg	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and Physical, documentation of medical necessity

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Code List

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J3121	Injection, testosterone enanthate, 1 mg	Advance Benefit Determination (ABD) recommended	Medical Necessity	For males <18 years: Submit history and physical confirming diagnosis of delay in sexual development and/or puberty; bone age to be assessed, including liver function tests, and hematocrit levels; for males 18 and older: Submit history and physical and baseline with annual PSA for patients over age 40 (prostatectomy excluded from the requirement). For males or females: Monitor heart attack, stroke, and cancer risks, as well as regular monitoring of liver function tests, and hematocrit levels
J3241	Injection, teprotumumab-trbw, 10 mg	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, including recent lab work and any other attempted medications and response(s), if applicable
J3247	Injection, secukinumab, intravenous, 1 mg	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history and physical, documentation of medical necessity.
J3262	Injection, tocilizumab, 1 mg (Actemra)	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical demonstrating reason for requested medication, dosage and duration of treatment, office notes related to condition
J3263	Injection, toripalimab-tpzi, 1 mg	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history and physical, documentation of medical necessity.
J3285	Injection, treprostinil, 1 mg	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical demonstrating reason for requested medication, lab work (if applicable), dosage and duration of treatment, office notes related to condition, documentation of medical necessity, and documentation of previous therapies/treatments tried
J3299	Injection, triamcinolone acetonide (Xipere), 1 mg	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and Physical, documentation of medical necessity

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
J3304	Injection, triamcinolone acetonide, preservative-free, extended-release, microsphere formulation, 1 mg	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, documentation of medical necessity, treatment plan
J3315	Injection, triptorelin pamoate, 3.75 mg	Prior Authorization Required	Medical Necessity	History and physical, documentation of infertility, treatment plan
J3316	Injection, triptorelin, extended-release, 3.75 mg	Prior Authorization Required	Medical Necessity	History and physical, documentation of infertility, treatment plan
J3357	Ustekinumab, for subcutaneous injection, 1 mg	Prior Authorization Required	Medical Necessity	History and physical, and clinical notes of condition being treated, including documentation of previous therapies tried and failed, and proposed treatment plan
J3358	Ustekinumab, for intravenous injection, 1 mg	Prior Authorization Required	Medical Necessity	History and physical, and clinical notes of condition being treated, including documentation of previous therapies tried and failed, and proposed treatment plan
J3380	Injection, Vedolizumab, intravenous 1 mg	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and Physical, clinical notes from ordering provider, treatment plan
J3385	Injection, velaglucerase alfa, 100 units	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history and physical, documentation of medical necessity.
J3387	Injection, elivaldogene autotemcel, per treatment	Prior Authorization Required	Medical Necessity	History and Physical, clinical notes related to a condition being treated, documentation of previous therapies tried and failed.
J3389	Topical administration, prademagene zamikeracel, per treatment	Prior Authorization Required	Medical Necessity	History and Physical, clinical notes related to a condition being treated, documentation of previous therapies tried and failed.
J3391	Injection, atidarsagene autotemcel, per treatment	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
J3392	Injection, exagamglogene autotemcel, per treatment	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.

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J3393	Injection, betibeglogene autotemcel, per treatment	Prior Authorization Required	Medical Necessity	Submit History and Physical, documentation of medical necessity NOTE: Claims for this drug are processed through the Local Plan, not pharmacy.
J3394	Injection, lovotibeglogene autotemcel, per treatment	Prior Authorization Required	Medical Necessity	Submit History and Physical, documentation of medical necessity NOTE: Claims for this drug are processed through the Local Plan, not pharmacy.
J3398	Injection, voretigene neparvovec-rzyl, 1 billion vector genomes	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, and treatment plan. Note: Claims for this drug are processed through the local plan, not pharmacy
J3399	Injection, onasemnogene abeparvovec-xioi, per treatment, up to 5x10^15 vector genomes	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, and treatment plan. Note: Claims for this drug are processed through the local plan, not pharmacy
J3400	Injection, triflupromazine HCl, up to 20 mg	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
J3401	Beremagene geperpavec-svdt for topical administration, containing nominal 5x10^9 pfu/ml vector genomes, per 0.1 ml	Prior Authorization Required	Medical Necessity	History and physical demonstrating reason for requested medication, documentation of medical necessity, and documentation of previous therapies tried and failed
J3465	Injection, voriconazole, 10 mg	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and Physical, documentation of medical necessity
J3490	Unclassified drugs	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, including recent lab work and any other attempted medications and response(s), if applicable
J3570	Laetrile, amygdalin, vitamin B-17	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.

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J3590	Unclassified biologics	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, documentation of medical necessity, and documentation of previous therapies/treatments tried
J3591	Unclassified drug or biological used for ESRD on dialysis	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, including drug name
J7173	Injection, concizumab-mtci, 0.5 mg	Prior Authorization Required	Medical Necessity	History and Physical, clinical notes related to a condition being treated, documentation of previous therapies tried and failed.
J7318	Hyaluronan or derivative, durolane, for intra-articular injection, 1 mg	Prior Authorization Required	Medical Necessity	History and physical; including X-ray results, prior steroid injection response, and conservative non-pharmacologic and pharmacologic treatments tried.
J7320	Hyaluronan or derivative, Genvisc 850, for intra-articular injection, 1 MG	Prior Authorization Required	Medical Necessity	History and physical; including X-ray results, prior steroid injection response, and conservative non-pharmacologic and pharmacologic treatments tried.
J7321	Hyaluronan or derivative, Hyalgan, Supartz or Visco-3, for intra-articular injection, per dose	Prior Authorization Required	Medical Necessity	History and physical; including X-ray results, prior steroid injection response, and conservative non-pharmacologic and pharmacologic treatments tried.
J7322	Hyaluronan or derivative, Hymovis or Hymovis One, for intra-articular injection, 1 MG	Prior Authorization Required	Medical Necessity	History and physical; including X-ray results, prior steroid injection response, and conservative non-pharmacologic and pharmacologic treatments tried.

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J7323	Hyaluronan or derivative, Euflexxa, for intra-articular injection, per dose	Prior Authorization Required	Medical Necessity	History and physical; including X-ray results, prior steroid injection response, and conservative non-pharmacologic and pharmacologic treatments tried.
J7324	Hyaluronan or derivative, Orthovisc, for intra-articular injection, per dose	Prior Authorization Required	Medical Necessity	History and physical; including X-ray results, prior steroid injection response, and conservative non-pharmacologic and pharmacologic treatments tried.
J7325	Hyaluronan or derivative, Synvisc or Synvisc-One, for intra-articular injection, 1 mg	Prior Authorization Required	Medical Necessity	History and physical; including X-ray results, prior steroid injection response, and conservative non-pharmacologic and pharmacologic treatments tried.
J7326	Hyaluronan or derivative, Gel-One, for intra-articular injection, per dose	Prior Authorization Required	Medical Necessity	History and physical; including X-ray results, prior steroid injection response, and conservative non-pharmacologic and pharmacologic treatments tried.
J7327	Hyaluronan or derivative, Monovisc, for intra-articular injection, per dose	Prior Authorization Required	Medical Necessity	History and physical; including X-ray results, prior steroid injection response, and conservative non-pharmacologic and pharmacologic treatments tried.
J7328	Hyaluronan or derivative, Gel-Syn, for intra-articular injection, 0.1 MG	Prior Authorization Required	Medical Necessity	History and physical; including X-ray results, prior steroid injection response, and conservative non-pharmacologic and pharmacologic treatments tried.
J7329	Hyaluronan or derivative, trivisc, for intra-articular injection, 1 mg	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical; including X-ray results, prior steroid injection response, and conservative non-pharmacologic and pharmacologic treatments tried.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
J7330	Autologous cultured chondrocytes, implant	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, pre-operative evaluations, imaging reports, conservative measures, operative report, and anesthesia report
J7331	Hyaluronan or derivative, SYNOJOYNT, for intra-articular injection, 1 mg	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical; including X-ray results, prior steroid injection response, and conservative non-pharmacologic and pharmacologic treatments tried.
J7331	Hyaluronan or derivative, SYNOJOYNT, for intra-articular injection, 1 mg	Prior Authorization Required	Medical Necessity	History and physical; including X-ray results, prior steroid injection response, and conservative non-pharmacologic and pharmacologic treatments tried.
J7332	Hyaluronan or derivative, Triluron, for intra-articular injection, 1 mg	Prior Authorization Required	Medical Necessity	History and physical; including X-ray results, prior steroid injection response, and conservative non-pharmacologic and pharmacologic treatments tried.
J7352	Afamelanotide implant, 1 mg	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history and physical, documentation of medical necessity.
J7402	Mometasone furoate sinus implant, (Sinuva), 10 mcg	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and Physical, documentation of medical necessity
J7504	Lymphocyte immune globulin, antithymocyte globulin, equine, parenteral, 250 mg	Advance Benefit Determination (ABD) recommended	Medical Necessity	If transplant approval on record: Date of Transplant If no Transplant approval: History and Physical, Transplant evaluation, and date of transplant
J7699	NOC drugs, inhalation solution administered through DME	Prior Authorization Required	Medical Necessity	History and physical, including primary condition being treated and response to prior treatments; name of drug is needed
J7799	NOC drugs, other than inhalation drugs, administered through DME	Prior Authorization Required	Medical Necessity	History and physical, including primary condition being treated and response to prior treatments; name of drug is needed

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
J7999	Compounded drug, not otherwise classified	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit documentation to describe the medication, Include chart notes with drug name, NDC number and quantity.
J8498	Antiemetic drug, rectal/suppository, not otherwise specified	Prior Authorization Required	Medical Necessity	History and physical, including primary condition being treated and response to prior treatments; name of drug is needed
J8499	Prescription drug, oral, non-chemotherapeutic, NOS (Includes: Revlimid)	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, documentation of medical necessity, and documentation of previous therapies/treatments tried
J8597	Antiemetic drug, oral, not otherwise specified	Prior Authorization Required	Medical Necessity	History and physical, including primary condition being treated and response to prior treatments; name of drug is needed
J8650	Nabilone, oral, 1 mg	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and Physical, documentation of medical necessity
J8999	Prescription drug, oral, chemotherapeutic, NOS (includes: Sprycel and Tasigna, Erlotinib, Nexavar and Sutent)	Prior Authorization Required	Medical Necessity	History and physical, including primary condition being treated and response to prior treatments; name of drug is needed
J9011	Injection, datopotamab deruxtecan-dlnk, 1 mg	Prior Authorization Required	Medical Necessity	History and Physical, clinical notes related to a condition being treated, documentation of previous therapies tried and failed.
J9019	Injection, asparaginase (Erwinaze), 1,000 IU	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history and physical, documentation of medical necessity.
J9021	Injection, asparaginase, recombinant, (Rylaze), 0.1 mg	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and Physical, documentation of medical necessity
J9022	Injection, atezolizumab, 10 mg	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, documentation of medical necessity and previously tried therapies
J9023	Injection, avelumab, 10 mg	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and Physical, documentation of medical necessity

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J9024	Injection, atezolizumab, 5 mg and hyaluronidase-tqjs	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, documentation of medical necessity and previously tried therapies
J9026	Injection, tarlatamab-dlle, 1 mg	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and Physical, clinical notes related to a condition being treated, documentation of previous therapies tried and failed.
J9028	Injection, nogapendekin alfa inbakicept-pmln, for intravesical use, 1 microgram	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and Physical, clinical notes related to a condition being treated, documentation of previous therapies tried and failed.
J9029	Intravesical instillation, nadofaragene firadenovec-vncg, per therapeutic dose	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, and treatment plan. Note: Claims for this drug are processed through the local plan, not pharmacy
J9032	Injection, Belinostat, 10 MG	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and Physical, including prior treatments and proposed treatment plan
J9033	Injection, Bendamustine Hydrochloride, not otherwise specified, 1mg	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history and physical, documentation of medical necessity.
J9034	Injection, bendamustine HCl (Bendeka), 1 mg	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history and physical, documentation of medical necessity.
J9035	Injection, bevacizumab, 10 mg	Prior Authorization Required	Medical Necessity	History and physical, and clinical notes of condition being treated, including documentation of previous therapies tried and failed, and proposed treatment plan
J9036	Injection, bendamustine HCl, (Belrapzo/bendamustine), 1 mg	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and Physical, documentation of medical necessity
J9038	Injection, axatilimab-csfr, 0.1 mg	Prior Authorization Required	Medical Necessity	History and Physical, clinical notes related to a condition being treated, documentation of previous therapies tried and failed.
J9039	Injection, blinatumomab, 1 mcg	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and Physical, clinical notes from ordering provider, treatment plan

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J9041	Injection, bortezomib, 0.1 mg	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, documentation of medical necessity and previously tried therapies
J9042	Injection, brentuximab vedotin, 1 mg	Advance Benefit Determination (ABD) recommended	Medical Necessity	Please submit the history and physical, including history of failed autologous stem cell transplant (ASCT) or failure of at least two prior multi-agent chemotherapy regimens if member is not an ASCT candidate.
J9042	Injection, brentuximab vedotin, 1 mg	Prior Authorization Required	Medical Necessity	Submit the history and physical, including history of failed autologous stem cell transplant (ASCT) or failure of at least two prior multi-agent chemotherapy regimens if member is not an ASCT candidate
J9043	Injection, cabazitaxel, 1 mg	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history and physical, documentation of medical necessity.
J9044	Injection, bortezomib, not otherwise specified, 0.1 mg	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and Physical, documentation of medical necessity
J9046	Injection, bortezomib (Dr. Reddy's), not therapeutically equivalent to J9041, 0.1 mg	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, documentation of medical necessity and previously tried therapies
J9047	Injection, carfilzomib, 1 mg	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and Physical, documentation of medical necessity including prior treatments
J9048	Injection, bortezomib (Fresenius Kabi), not therapeutically equivalent to J9041, 0.1 mg	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, documentation of medical necessity and previously tried therapies
J9049	Injection, bortezomib (Hospira), not therapeutically equivalent to J9041, 0.1 mg	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, documentation of medical necessity and previously tried therapies
J9051	Injection, Bortezomib (MAIA), not therapeutically equivalent to J9041, 0.1 mg	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, documentation of medical necessity and previously tried therapies
J9054	Injection, bortezomib (boruzu), 0.1 mg	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, documentation of medical necessity and previously tried therapies

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J9055	Injection, cetuximab, 10 mg	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and Physical, including prior treatments and proposed treatment plan
J9056	Injection, bendamustine HCl (Vivimusta), 1 mg	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, documentation of medical necessity, treatment plan
J9057	Injection, copanlisib, 1 mg	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, documentation of medical necessity, treatment plan
J9061	Injection, amivantamab-vmjw, 2 mg	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and Physical, documentation of medical necessity
J9063	Injection, mirvetuximab soravtansine-gynx, 1 mg	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and Physical, documentation of medical necessity
J9064	Injection, cabazitaxel (Sandoz), not therapeutically equivalent to J9043, 1 mg	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and Physical, documentation of medical necessity
J9118	Injection, calaspargase pegol-mknl, 10 units	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and Physical, documentation of medical necessity
J9119	Injection, cemiplimab-rwlc, 1 mg	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, documentation of medical necessity, treatment plan
J9144	Injection, daratumumab, 10 mg and hyaluronidase-fihj	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, including recent lab work and any other attempted medications and response(s), if applicable
J9145	Injection, daratumumab, 10 mg	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and Physical, clinical notes from ordering provider, treatment plan
J9153	Injection, liposomal, 1 mg daunorubicin and 2.27 mg cytarabine	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and Physical, documentation of medical necessity
J9155	Injection, degarelix, 1 mg	Prior Authorization Required	Medical Necessity	History and physical, documentation of infertility, treatment plan
J9173	Injection, durvalumab, 10 mg	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and Physical, documentation of medical necessity
J9176	Injection, elotuzumab, 1 mg	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and Physical, clinical notes from ordering provider, treatment plan
J9177	Injection, enfortumab vedotin-ejfv, 0.25 mg	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and Physical, documentation of medical necessity

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J9179	Injection, eribulin mesylate, 0.1 mg	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and Physical, documentation of medical necessity including prior treatments
J9202	Goserelin acetate implant, per 3.6 mg	Prior Authorization Required	Medical Necessity	History and physical, documentation of infertility, treatment plan.For non infertility services, medical necessity review will be performed upon claims submission with supporting documentation.
J9203	Injection, gemtuzumab ozogamicin, 0.1 mg	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and Physical, documentation of medical necessity
J9204	Injection, mogamulizumab-kpkc, 1 mg	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and Physical, documentation of medical necessity
J9205	Injection, irinotecan liposome, 1 mg	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and Physical, clinical notes from ordering provider, treatment plan
J9210	Injection, emapalumab-lzsg, 1 mg	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, documentation of medical necessity, treatment plan
J9212	Injection, interferon alfacon-1, recombinant, 1 mcg	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and Physical, documentation of medical necessity
J9213	Injection, interferon, alfa-2a, recombinant, 3 million units	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and Physical, documentation of medical necessity
J9216	Injection, interferon, gamma 1-b, 3 million units	Advance Benefit Determination (ABD) recommended	Medical Necessity	Direct providers and members to the Specialty Pharmacy Program at 888-346-3731 or visit the Pharmacy section on www.fepblue.org
J9217	Leuprolide acetate (for depot suspension), 7.5 mg	Prior Authorization Required	Medical Necessity	For infertility treatment, submit history and physical, and documentation of infertility and treatment plan; for non-fertility related treatment, submit a history and physical, and documentation of medical necessity
J9218	Leuprolide acetate, per 1 mg	Prior Authorization Required	Medical Necessity	For infertility treatment, submit history and physical, and documentation of infertility and treatment plan; for non-fertility related treatment, submit a history and physical, and documentation of medical necessity

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J9223	Injection, lurbinectedin, 0.1 mg	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history and physical, documentation of medical necessity.
J9226	Histrelin implant (Supprelin LA), 50 mg	Prior Authorization Required	Medical Necessity	History and physical, documentation of infertility, treatment plan
J9227	Injection, isatuximab-irfc, 10 mg	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and Physical, documentation of medical necessity
J9228	Injection, ipilimumab, 1 mg	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and Physical, including adrenocorticotropic hormone (ACTH) level, liver and thyroid function tests. Provider agrees to permanently discontinue Yervoy and initiate corticosteroid therapy for severe immune-mediated reactions.
J9229	Injection, inotuzumab ozogamicin, 0.1 mg	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and Physical, documentation of medical necessity
J9255	Injection, methotrexate (accord) not therapeutically equivalent to J9250 and J9260, 50 mg	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history and physical, documentation of medical necessity.
J9256	Injection, nipocalimab-aahu, 3 mg	Prior Authorization Required	Medical Necessity	History and Physical, clinical notes related to a condition being treated, documentation of previous therapies tried and failed.
J9266	Injection, pegaspargase, per single dose vial	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and Physical, documentation of medical necessity
J9269	Injection, tagraxofusp-erzs, 10 mcg	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, documentation of medical necessity, treatment plan
J9271	Injection, pembrolizumab, 1 mg	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, including recent lab work and any other attempted medications and response(s), if applicable
J9272	Injection, dostarlimab-gxly, 10 mg	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, documentation of medical necessity and previously tried therapies
J9273	Injection, tisotumab vedotin-tftv, 1 mg	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and Physical, documentation of medical necessity

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J9274	Injection, tebentafusp-tebn, 1 mcg	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and Physical, documentation of medical necessity
J9275	Injection, cosibelimab-ipdl, 2 mg	Prior Authorization Required	Medical Necessity	History and Physical, clinical notes related to a condition being treated, documentation of previous therapies tried and failed.
J9277	Injection, pembrolizumab, 1 mg and berahyaluronidase alfa-pmph (Keytruda Qlex)	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, including recent lab work and any other attempted medications and response(s), if applicable
J9281	Mitomycin pyelocalyceal instillation, 1 mg	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history and physical, documentation of medical necessity.
J9285	Injection, olaratumab, 10 mg	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, documentation of medical necessity, treatment plan
J9286	Injection, glofitamab-gxbm, 2.5 mg	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history and physical, documentation of medical necessity.
J9289	Injection, nivolumab, 2 mg and hyaluronidase-nvhy	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and Physical, documentation of medical necessity
J9295	Injection, necitumumab, 1 mg	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and Physical, documentation of medical necessity
J9298	Injection, nivolumab and relatlimab-rmbw, 3 mg/1 mg	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and Physical, documentation of medical necessity
J9299	Injection, Nivolumab, 1 MG	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, including recent lab work and any other attempted medications and response(s), if applicable
J9301	Injection, obinutuzumab, 10 mg	Advance Benefit Determination (ABD) recommended	Medical Necessity	Please request the H&P, the clinical notes for medical necessity.
J9302	Injection, ofatumumab, 10 mg (Arzerra)	Advance Benefit Determination (ABD) recommended	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	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and Physical, including prior treatments and proposed treatment plan

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Code List

Code	Description	Plan Review Requirement	Reviewed For	Records Request
J9306	Injection, pertuzumab, 1 mg	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, including recent lab work and any other attempted medications and response(s), if applicable
J9308	Injection, ramucirumab, 5 mg	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and Physical, documentation of medical necessity including prior treatments
J9309	Injection, polatuzumab vedotin-piiq, 1 mg	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and Physical, documentation of medical necessity
J9311	Injection, rituximab 10 mg and hyaluronidase	Prior Authorization Required	Medical Necessity	History and physical, and clinical notes of condition being treated, including documentation of previous therapies tried and failed, and proposed treatment plan
J9312	Injection, rituximab, 10 mg	Prior Authorization Required	Medical Necessity	History and physical, and clinical notes of condition being treated, including documentation of previous therapies tried and failed, and proposed treatment plan
J9316	Injection, pertuzumab, trastuzumab, and hyaluronidase-zzxf, per 10 mg	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history and physical, documentation of medical necessity.
J9317	Injection, sacituzumab govitecan-hziy, 2.5 mg	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history and physical, documentation of medical necessity.
J9318	Injection, romidepsin, nonlyophilized, 0.1 mg	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and Physical, documentation of medical necessity
J9319	Injection, romidepsin, lyophilized, 0.1 mg	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and Physical, documentation of medical necessity
J9321	Injection, epcoritamab-bysp, 0.16 mg	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history and physical, documentation of medical necessity.
J9325	Injection, Talimogene Laherparepvec, per 1 Million Plaque Forming Units	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and Physical, clinical notes from ordering provider, treatment plan
J9326	Injection, telisotuzumab vedotin-tllv, 1 mg	Prior Authorization Required	Medical Necessity	History and Physical, clinical notes related to a condition being treated, documentation of previous therapies tried and failed.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
J9329	Injection, tislelizumab-jsgr, 1mg	Prior Authorization Required	Medical Necessity	History and Physical, clinical notes related to a condition being treated, documentation of previous therapies tried and failed.
J9331	Injection, sirolimus protein-bound particles, 1 mg	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and Physical, documentation of medical necessity
J9332	Injection, efgartigimod alfa-fcab, 2 mg	Prior Authorization Required	Medical Necessity	History and physical, and clinical notes of condition being treated, including documentation of previous therapies tried and failed, and proposed treatment plan
J9333	Injection, rozanolixizumab-noli, 1 mg	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and Physical, documentation of medical necessity NOTE: Claims for this drug are processed through the Local Plan, not pharmacy.
J9333	Injection, rozanolixizumab-noli, 1 mg	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, including recent lab work and any other attempted medications and response(s), if applicable
J9334	Injection, efgartigimod alfa, 2 mg and hyaluronidase-qvfc	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and Physical, clinical notes related to a condition being treated, documentation of previous therapies tried and failed.
J9345	Injection, Retifanlimab-DLWR, 1 mg	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and Physical, documentation of medical necessity
J9347	Injection, tremelimumab-actl, 1 mg	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and Physical, documentation of medical necessity
J9348	Injection, naxitamab-gqgk, 1 mg	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and Physical, documentation of medical necessity
J9349	Injection, tafasitamab-cxix, 2 mg	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and Physical, documentation of medical necessity
J9350	Injection, mosunetuzumab-axgb, 1 mg	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and Physical, documentation of medical necessity
J9353	Injection, margetuximab-cmkb, 5 mg	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and Physical, documentation of medical necessity

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Code List

Code	Description	Plan Review Requirement	Reviewed For	Records Request
J9354	Injection, ado-trastuzumab emtansine, 1 mg	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, including recent lab work and any other attempted medications and response(s), if applicable
J9355	Injection, trastuzumab, excludes biosimilar, 10 mg	Prior Authorization Required	Medical Necessity	History and physical, and clinical notes of condition being treated, including documentation of previous therapies tried and failed, and proposed treatment plan
J9356	Injection, bendamustine hydrochloride, (Belrapzo/bendamustine), 1 mg	Prior Authorization Required	Medical Necessity	History and physical, and clinical notes of condition being treated, including documentation of previous therapies tried and failed, and proposed treatment plan
J9358	Injection, fam-trastuzumab deruxtecan-nxki, 1 mg	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, previous treatments, lab work demonstrating HER-2/neu over expression. Do not send infusion records!
J9358	Injection, fam-trastuzumab deruxtecan-nxki, 1 mg	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, including recent lab work and any other attempted medications and response(s), if applicable
J9359	Injection, loncastuximab tesirine-lpyl, 0.075 mg	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and Physical, documentation of medical necessity
J9376	Injection, pozelimab-bbfg, 1 mg	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and Physical, documentation of medical necessity
J9380	Injection, Teclistamab-cqyv, 0.5 mg	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, and treatment plan. Note: Claims for this drug are processed through the local plan, not pharmacy
J9381	Injection, teplizumab-mzwv, 5 mcg	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history and physical, documentation of medical necessity.
J9382	Injection, zenocutuzumab-zbco, 1 mg	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and Physical, documentation of medical necessity

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J9400	Injection, ziv-aflibercept, 1 mg	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, documentation of medical necessity, treatment plan
J9999	Not otherwise classified, antineoplastic drugs	Prior Authorization Required	Medical Necessity	History and physical, clinical notes related to a condition being treated, documentation of medical necessity, including name of drug and NDC number and quantity; if drug is Tecartus, prior approval needed for all plan types. Claims for Tecartus and Zepzelca are processed through the local plan, not pharmacy. medical necessity review will be performed upon claims submission with supporting documentation
K0001	Standard wheelchair	Medical necessity review will be performed upon claims submission with supporting documentation	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, and evaluation of upper extremity strength)
K0005	Ultralight weight wheelchair	Medical necessity review will be performed upon claims submission with supporting documentation	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, and evaluation of upper extremity strength)

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
K0008	Custom manual wheelchair base	Medical necessity review will be performed upon claims submission with supporting documentation	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, and evaluation of upper extremity strength)
K0010	Standard – weight frame motorized/power wheelchair	Prior Authorization Required	Medical Necessity	Documentation of medical condition, abilities/limitations as they relate to the equipment including reasoning for type of equipment (degree of independence/dependence, frequency, and nature of the activities performed), duration of the medical condition, experience (if any) using similar equipment, evaluation of upper extremity strength with documented inability to propel a manual wheelchair.
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	Documentation of medical condition, abilities/limitations as they relate to the equipment including reasoning for type of equipment (degree of independence/dependence, frequency, and nature of the activities performed), duration of the medical condition, experience (if any) using similar equipment, evaluation of upper extremity strength with documented inability to propel a manual wheelchair.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
K0012	Lightweight portable motorized/power wheelchair	Prior Authorization Required	Medical Necessity	Documentation of medical condition, abilities/limitations as they relate to the equipment including reasoning for type of equipment (degree of independence/dependence, frequency, and nature of the activities performed), duration of the medical condition, experience (if any) using similar equipment, evaluation of upper extremity strength with documented inability to propel a manual wheelchair.
K0013	Custom motorized/power wheelchair base	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical condition/diagnosis, abilitites and limitations as they relate to the equipment (degree of independence/dependence, frequency, and nature of the activities performed), duration of the medical condition, and past experience (if any) using similar equipment. medical necessity review will be performed upon claims submission with supporting documentation
K0014	Other motorized/power wheelchair base	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical condition/diagnosis, abilitites and limitations as they relate to the equipment (degree of independence/dependence, frequency, and nature of the activities performed), duration of the medical condition, and past experience (if any) using similar equipment
K0108	Wheelchair component or accessory, not otherwise specified	Prior Authorization Required	Medical Necessity	Description of the wheelchair component/accessory and letter of medical necessity supporting need for the wheelchair component/accessory

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Code List

Code	Description	Plan Review Requirement	Reviewed For	Records Request
K0607	Replacement battery for automated external defibrillator, each	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical and documentation of medical necessity, including plan of care. medical necessity review will be performed upon claims submission with supporting documentation
K0608	Replacement garment for use with automated external defibrillator, each	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical and documentation of medical necessity, including plan of care. medical necessity review will be performed upon claims submission with supporting documentation
K0609	Replacement electrodes for use with automated external defibrillator, each	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical and documentation of medical necessity, including plan of care. medical necessity review will be performed upon claims submission with supporting documentation
K0669	Wheelchair accessory, wheelchair seat or back cushion, does not meet specific code criteria or no written coding verification from SADMERC	Advance Benefit Determination (ABD) recommended	Medical Necessity	Letter of medical necessity supporting the need for the wheelxhair accessory. medical necessity review will be performed upon claims submission with supporting documentation
K0733	Power wheelchair accessory, 12 to 24 amp hour sealed lead acid battery, each (e.g. gel cell, absorbed glassmat)	Prior Authorization Required	Medical Necessity	History and physical, and documentation of medical necessity. medical necessity review will be performed upon claims submission with supporting documentation

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Code List

Code	Description	Plan Review Requirement	Reviewed For	Records Request
K0800	Power operated vehicle, group 1 standard, patient weight capacity up to and including 300 pounds	Prior Authorization Required	Medical Necessity	History and physical, including documentation of medical condition/diagnosis, abilitites and limitations as they relate to the equipment (degree of independence/dependence, frequency, and nature of the activities performed), duration of the medical condition, past experience (if any) using similar equipment, and evaluation of upper extremity strength. medical necessity review will be performed upon claims submission with supporting documentation
K0801	Power operated vehicle, group 1 heavy-duty, patient weight capacity 301 to 450 pounds	Prior Authorization Required	Medical Necessity	History and physical, including documentation of medical condition/diagnosis, abilitites and limitations as they relate to the equipment (degree of independence/dependence, frequency, and nature of the activities performed), duration of the medical condition, past experience (if any) using similar equipment, and evaluation of upper extremity strength. medical necessity review will be performed upon claims submission with supporting documentation

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
K0802	Power operated vehicle, group 1 very heavy-duty, patient weight capacity 451 to 600 pounds	Prior Authorization Required	Medical Necessity	History and physical, including documentation of medical condition/diagnosis, abilitites and limitations as they relate to the equipment (degree of independence/dependence, frequency, and nature of the activities performed), duration of the medical condition, past experience (if any) using similar equipment, and evaluation of upper extremity strength. medical necessity review will be performed upon claims submission with supporting documentation
K0806	Power operated vehicle, group 2 standard, patient weight capacity up to and including 300 pounds	Prior Authorization Required	Medical Necessity	History and physical, including documentation of medical condition/diagnosis, abilitites and limitations as they relate to the equipment (degree of independence/dependence, frequency, and nature of the activities performed), duration of the medical condition, past experience (if any) using similar equipment, and evaluation of upper extremity strength. medical necessity review will be performed upon claims submission with supporting documentation

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Code List

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	History and physical, including documentation of medical condition/diagnosis, abilitites and limitations as they relate to the equipment (degree of independence/dependence, frequency, and nature of the activities performed), duration of the medical condition, past experience (if any) using similar equipment, and evaluation of upper extremity strength. medical necessity review will be performed upon claims submission with supporting documentation
K0808	Power operated vehicle, group 2 very heavy-duty, patient weight capacity 451 to 600 pounds	Prior Authorization Required	Medical Necessity	History and physical, including documentation of medical condition/diagnosis, abilitites and limitations as they relate to the equipment (degree of independence/dependence, frequency, and nature of the activities performed), duration of the medical condition, past experience (if any) using similar equipment, and evaluation of upper extremity strength. medical necessity review will be performed upon claims submission with supporting documentation

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
K0812	Power operated vehicle, not otherwise classified	Prior Authorization Required	Medical Necessity	History and physical, including documentation of medical condition/diagnosis, abilitites and limitations as they relate to the equipment (degree of independence/dependence, frequency, and nature of the activities performed), duration of the medical condition, past experience (if any) using similar equipment, and evaluation of upper extremity strength. medical necessity review will be performed upon claims submission with supporting documentation
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	History and physical, including documentation of medical condition/diagnosis, abilitites and limitations as they relate to the equipment (degree of independence/dependence, frequency, and nature of the activities performed), duration of the medical condition, past experience (if any) using similar equipment, and evaluation of upper extremity strength. medical necessity review will be performed upon claims submission with supporting documentation

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Code List

Code	Description	Plan Review Requirement	Reviewed For	Records Request
K0814	Power wheelchair, group 1 standard, portable, captain's chair, patient weight capacity up to and including 300 pounds	Prior Authorization Required	Medical Necessity	History and physical, including documentation of medical condition/diagnosis, abilitites and limitations as they relate to the equipment (degree of independence/dependence, frequency, and nature of the activities performed), duration of the medical condition, past experience (if any) using similar equipment, and evaluation of upper extremity strength. medical necessity review will be performed upon claims submission with supporting documentation
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	History and physical, including documentation of medical condition/diagnosis, abilitites and limitations as they relate to the equipment (degree of independence/dependence, frequency, and nature of the activities performed), duration of the medical condition, past experience (if any) using similar equipment, and evaluation of upper extremity strength. medical necessity review will be performed upon claims submission with supporting documentation

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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	History and physical, including documentation of medical condition/diagnosis, abilitites and limitations as they relate to the equipment (degree of independence/dependence, frequency, and nature of the activities performed), duration of the medical condition, past experience (if any) using similar equipment, and evaluation of upper extremity strength. medical necessity review will be performed upon claims submission with supporting documentation
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	History and physical, including documentation of medical condition/diagnosis, abilitites and limitations as they relate to the equipment (degree of independence/dependence, frequency, and nature of the activities performed), duration of the medical condition, past experience (if any) using similar equipment, and evaluation of upper extremity strength. medical necessity review will be performed upon claims submission with supporting documentation

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Code List

Code	Description	Plan Review Requirement	Reviewed For	Records Request
K0821	Power wheelchair, group 2 standard, portable, captain's chair, patient weight capacity up to and including 300 pounds	Prior Authorization Required	Medical Necessity	History and physical, including documentation of medical condition/diagnosis, abilitites and limitations as they relate to the equipment (degree of independence/dependence, frequency, and nature of the activities performed), duration of the medical condition, past experience (if any) using similar equipment, and evaluation of upper extremity strength. medical necessity review will be performed upon claims submission with supporting documentation
K0822	Power wheelchair, group 2 standard, sling/solid seat/back, patient weight capacity up to and including 300 pounds	Prior Authorization Required	Medical Necessity	History and physical, including documentation of medical condition/diagnosis, abilitites and limitations as they relate to the equipment (degree of independence/dependence, frequency, and nature of the activities performed), duration of the medical condition, past experience (if any) using similar equipment, and evaluation of upper extremity strength. medical necessity review will be performed upon claims submission with supporting documentation

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
K0823	Power wheelchair, group 2 standard, captain's chair, patient weight capacity up to and including 300 pounds	Prior Authorization Required	Medical Necessity	History and physical, including documentation of medical condition/diagnosis, abilitites and limitations as they relate to the equipment (degree of independence/dependence, frequency, and nature of the activities performed), duration of the medical condition, past experience (if any) using similar equipment, and evaluation of upper extremity strength. medical necessity review will be performed upon claims submission with supporting documentation
K0824	Power wheelchair, group 2 heavy-duty, sling/solid seat/back, patient weight capacity 301 to 450 pounds	Prior Authorization Required	Medical Necessity	History and physical, including documentation of medical condition/diagnosis, abilitites and limitations as they relate to the equipment (degree of independence/dependence, frequency, and nature of the activities performed), duration of the medical condition, past experience (if any) using similar equipment, and evaluation of upper extremity strength. medical necessity review will be performed upon claims submission with supporting documentation

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Code List

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	History and physical, including documentation of medical condition/diagnosis, abilitites and limitations as they relate to the equipment (degree of independence/dependence, frequency, and nature of the activities performed), duration of the medical condition, past experience (if any) using similar equipment, and evaluation of upper extremity strength. medical necessity review will be performed upon claims submission with supporting documentation
K0826	Power wheelchair, group 2 very heavy duty, sling/solid seat/back, patient weight capacity 451 to 600 pounds	Prior Authorization Required	Medical Necessity	History and physical, including documentation of medical condition/diagnosis, abilitites and limitations as they relate to the equipment (degree of independence/dependence, frequency, and nature of the activities performed), duration of the medical condition, past experience (if any) using similar equipment, and evaluation of upper extremity strength. medical necessity review will be performed upon claims submission with supporting documentation

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Code List

Code	Description	Plan Review Requirement	Reviewed For	Records Request
K0827	Power wheelchair, group 2 very heavy-duty, captain's chair, patient weight capacity 451 to 600 pounds	Prior Authorization Required	Medical Necessity	History and physical, including documentation of medical condition/diagnosis, abilitites and limitations as they relate to the equipment (degree of independence/dependence, frequency, and nature of the activities performed), duration of the medical condition, past experience (if any) using similar equipment, and evaluation of upper extremity strength. medical necessity review will be performed upon claims submission with supporting documentation
K0828	Power wheelchair, group 2 extra heavy-duty, sling/solid seat/back, patient weight capacity 601 pounds or more	Prior Authorization Required	Medical Necessity	History and physical, including documentation of medical condition/diagnosis, abilitites and limitations as they relate to the equipment (degree of independence/dependence, frequency, and nature of the activities performed), duration of the medical condition, past experience (if any) using similar equipment, and evaluation of upper extremity strength. medical necessity review will be performed upon claims submission with supporting documentation

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
K0829	Power wheelchair, group 2 extra heavy-duty, captain's chair, patient weight 601 pounds or more	Prior Authorization Required	Medical Necessity	History and physical, including documentation of medical condition/diagnosis, abilitites and limitations as they relate to the equipment (degree of independence/dependence, frequency, and nature of the activities performed), duration of the medical condition, past experience (if any) using similar equipment, and evaluation of upper extremity strength. medical necessity review will be performed upon claims submission with supporting documentation
K0830	Power wheelchair, group 2 standard, seat elevator, sling/solid seat/back, patient weight capacity up to and including 300 pounds	Prior Authorization Required	Medical Necessity	History and physical, including documentation of medical condition/diagnosis, abilitites and limitations as they relate to the equipment (degree of independence/dependence, frequency, and nature of the activities performed), duration of the medical condition, past experience (if any) using similar equipment, and evaluation of upper extremity strength. medical necessity review will be performed upon claims submission with supporting documentation

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Code List

Code	Description	Plan Review Requirement	Reviewed For	Records Request
K0831	Power wheelchair, group 2 standard, seat elevator, captain's chair, patient weight capacity up to and including 300 pounds	Prior Authorization Required	Medical Necessity	History and physical, including documentation of medical condition/diagnosis, abilitites and limitations as they relate to the equipment (degree of independence/dependence, frequency, and nature of the activities performed), duration of the medical condition, past experience (if any) using similar equipment, and evaluation of upper extremity strength. medical necessity review will be performed upon claims submission with supporting documentation
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	History and physical, including documentation of medical condition/diagnosis, abilitites and limitations as they relate to the equipment (degree of independence/dependence, frequency, and nature of the activities performed), duration of the medical condition, past experience (if any) using similar equipment, and evaluation of upper extremity strength. medical necessity review will be performed upon claims submission with supporting documentation

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Code List

Code	Description	Plan Review Requirement	Reviewed For	Records Request
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	History and physical, including documentation of medical condition/diagnosis, abilitites and limitations as they relate to the equipment (degree of independence/dependence, frequency, and nature of the activities performed), duration of the medical condition, past experience (if any) using similar equipment, and evaluation of upper extremity strength. medical necessity review will be performed upon claims submission with supporting documentation
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	History and physical, including documentation of medical condition/diagnosis, abilitites and limitations as they relate to the equipment (degree of independence/dependence, frequency, and nature of the activities performed), duration of the medical condition, past experience (if any) using similar equipment, and evaluation of upper extremity strength. medical necessity review will be performed upon claims submission with supporting documentation

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Code List

Code	Description	Plan Review Requirement	Reviewed For	Records Request
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	History and physical, including documentation of medical condition/diagnosis, abilitites and limitations as they relate to the equipment (degree of independence/dependence, frequency, and nature of the activities performed), duration of the medical condition, past experience (if any) using similar equipment, and evaluation of upper extremity strength. medical necessity review will be performed upon claims submission with supporting documentation
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	History and physical, including documentation of medical condition/diagnosis, abilitites and limitations as they relate to the equipment (degree of independence/dependence, frequency, and nature of the activities performed), duration of the medical condition, past experience (if any) using similar equipment, and evaluation of upper extremity strength. medical necessity review will be performed upon claims submission with supporting documentation

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Code List

Code	Description	Plan Review Requirement	Reviewed For	Records Request
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	History and physical, including documentation of medical condition/diagnosis, abilitites and limitations as they relate to the equipment (degree of independence/dependence, frequency, and nature of the activities performed), duration of the medical condition, past experience (if any) using similar equipment, and evaluation of upper extremity strength. medical necessity review will be performed upon claims submission with supporting documentation
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	History and physical, including documentation of medical condition/diagnosis, abilitites and limitations as they relate to the equipment (degree of independence/dependence, frequency, and nature of the activities performed), duration of the medical condition, past experience (if any) using similar equipment, and evaluation of upper extremity strength. medical necessity review will be performed upon claims submission with supporting documentation

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Code List

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	History and physical, including documentation of medical condition/diagnosis, abilitites and limitations as they relate to the equipment (degree of independence/dependence, frequency, and nature of the activities performed), duration of the medical condition, past experience (if any) using similar equipment, and evaluation of upper extremity strength. medical necessity review will be performed upon claims submission with supporting documentation
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	History and physical, including documentation of medical condition/diagnosis, abilitites and limitations as they relate to the equipment (degree of independence/dependence, frequency, and nature of the activities performed), duration of the medical condition, past experience (if any) using similar equipment, and evaluation of upper extremity strength. medical necessity review will be performed upon claims submission with supporting documentation

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Code List

Code	Description	Plan Review Requirement	Reviewed For	Records Request
K0848	Power wheelchair, group 3 standard, sling/solid seat/back, patient weight capacity up to and including 300 pounds	Prior Authorization Required	Medical Necessity	History and physical, including documentation of medical condition/diagnosis, abilitites and limitations as they relate to the equipment (degree of independence/dependence, frequency, and nature of the activities performed), duration of the medical condition, past experience (if any) using similar equipment, and evaluation of upper extremity strength. medical necessity review will be performed upon claims submission with supporting documentation
K0849	Power wheelchair, group 3 standard, captain's chair, patient weight capacity up to and including 300 pounds	Prior Authorization Required	Medical Necessity	History and physical, including documentation of medical condition/diagnosis, abilitites and limitations as they relate to the equipment (degree of independence/dependence, frequency, and nature of the activities performed), duration of the medical condition, past experience (if any) using similar equipment, and evaluation of upper extremity strength. medical necessity review will be performed upon claims submission with supporting documentation

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Code List

Code	Description	Plan Review Requirement	Reviewed For	Records Request
K0850	Power wheelchair, group 3 heavy-duty, sling/solid seat/back, patient weight capacity 301 to 450 pounds	Prior Authorization Required	Medical Necessity	History and physical, including documentation of medical condition/diagnosis, abilitites and limitations as they relate to the equipment (degree of independence/dependence, frequency, and nature of the activities performed), duration of the medical condition, past experience (if any) using similar equipment, and evaluation of upper extremity strength. medical necessity review will be performed upon claims submission with supporting documentation
K0851	Power wheelchair, group 3 heavy-duty, captain's chair, patient weight capacity 301 to 450 pounds	Prior Authorization Required	Medical Necessity	History and physical, including documentation of medical condition/diagnosis, abilitites and limitations as they relate to the equipment (degree of independence/dependence, frequency, and nature of the activities performed), duration of the medical condition, past experience (if any) using similar equipment, and evaluation of upper extremity strength. medical necessity review will be performed upon claims submission with supporting documentation

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Code List

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	History and physical, including documentation of medical condition/diagnosis, abilitites and limitations as they relate to the equipment (degree of independence/dependence, frequency, and nature of the activities performed), duration of the medical condition, past experience (if any) using similar equipment, and evaluation of upper extremity strength. medical necessity review will be performed upon claims submission with supporting documentation
K0853	Power wheelchair, group 3 very heavy-duty, captain's chair, patient weight capacity 451 to 600 pounds	Prior Authorization Required	Medical Necessity	History and physical, including documentation of medical condition/diagnosis, abilitites and limitations as they relate to the equipment (degree of independence/dependence, frequency, and nature of the activities performed), duration of the medical condition, past experience (if any) using similar equipment, and evaluation of upper extremity strength. medical necessity review will be performed upon claims submission with supporting documentation

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Code List

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K0854	Power wheelchair, group 3 extra heavy-duty, sling/solid seat/back, patient weight capacity 601 pounds or more	Prior Authorization Required	Medical Necessity	History and physical, including documentation of medical condition/diagnosis, abilitites and limitations as they relate to the equipment (degree of independence/dependence, frequency, and nature of the activities performed), duration of the medical condition, past experience (if any) using similar equipment, and evaluation of upper extremity strength. medical necessity review will be performed upon claims submission with supporting documentation
K0855	Power wheelchair, group 3 extra heavy duty, captain's chair, patient weight capacity 601 pounds or more	Prior Authorization Required	Medical Necessity	History and physical, including documentation of medical condition/diagnosis, abilitites and limitations as they relate to the equipment (degree of independence/dependence, frequency, and nature of the activities performed), duration of the medical condition, past experience (if any) using similar equipment, and evaluation of upper extremity strength. medical necessity review will be performed upon claims submission with supporting documentation

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Code List

Code	Description	Plan Review Requirement	Reviewed For	Records Request
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	History and physical, including documentation of medical condition/diagnosis, abilitites and limitations as they relate to the equipment (degree of independence/dependence, frequency, and nature of the activities performed), duration of the medical condition, past experience (if any) using similar equipment, and evaluation of upper extremity strength. medical necessity review will be performed upon claims submission with supporting documentation
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	History and physical, including documentation of medical condition/diagnosis, abilitites and limitations as they relate to the equipment (degree of independence/dependence, frequency, and nature of the activities performed), duration of the medical condition, past experience (if any) using similar equipment, and evaluation of upper extremity strength. medical necessity review will be performed upon claims submission with supporting documentation

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Code List

Code	Description	Plan Review Requirement	Reviewed For	Records Request
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	History and physical, including documentation of medical condition/diagnosis, abilitites and limitations as they relate to the equipment (degree of independence/dependence, frequency, and nature of the activities performed), duration of the medical condition, past experience (if any) using similar equipment, and evaluation of upper extremity strength. medical necessity review will be performed upon claims submission with supporting documentation
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	History and physical, including documentation of medical condition/diagnosis, abilitites and limitations as they relate to the equipment (degree of independence/dependence, frequency, and nature of the activities performed), duration of the medical condition, past experience (if any) using similar equipment, and evaluation of upper extremity strength. medical necessity review will be performed upon claims submission with supporting documentation

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Code List

Code	Description	Plan Review Requirement	Reviewed For	Records Request
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	History and physical, including documentation of medical condition/diagnosis, abilitites and limitations as they relate to the equipment (degree of independence/dependence, frequency, and nature of the activities performed), duration of the medical condition, past experience (if any) using similar equipment, and evaluation of upper extremity strength. medical necessity review will be performed upon claims submission with supporting documentation
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	History and physical, including documentation of medical condition/diagnosis, abilitites and limitations as they relate to the equipment (degree of independence/dependence, frequency, and nature of the activities performed), duration of the medical condition, past experience (if any) using similar equipment, and evaluation of upper extremity strength. medical necessity review will be performed upon claims submission with supporting documentation

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Code List

Code	Description	Plan Review Requirement	Reviewed For	Records Request
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	History and physical, including documentation of medical condition/diagnosis, abilitites and limitations as they relate to the equipment (degree of independence/dependence, frequency, and nature of the activities performed), duration of the medical condition, past experience (if any) using similar equipment, and evaluation of upper extremity strength. medical necessity review will be performed upon claims submission with supporting documentation
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	History and physical, including documentation of medical condition/diagnosis, abilitites and limitations as they relate to the equipment (degree of independence/dependence, frequency, and nature of the activities performed), duration of the medical condition, past experience (if any) using similar equipment, and evaluation of upper extremity strength. medical necessity review will be performed upon claims submission with supporting documentation

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Code List

Code	Description	Plan Review Requirement	Reviewed For	Records Request
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	History and physical, including documentation of medical condition/diagnosis, abilitites and limitations as they relate to the equipment (degree of independence/dependence, frequency, and nature of the activities performed), duration of the medical condition, past experience (if any) using similar equipment, and evaluation of upper extremity strength. medical necessity review will be performed upon claims submission with supporting documentation
K0868	Power wheelchair, group 4 standard, sling/solid seat/back, patient weight capacity up to and including 300 pounds	Prior Authorization Required	Medical Necessity	History and physical, including documentation of medical condition/diagnosis, abilitites and limitations as they relate to the equipment (degree of independence/dependence, frequency, and nature of the activities performed), duration of the medical condition, past experience (if any) using similar equipment, and evaluation of upper extremity strength. medical necessity review will be performed upon claims submission with supporting documentation

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Code List

Code	Description	Plan Review Requirement	Reviewed For	Records Request
K0869	Power wheelchair, group 4 standard, captain's chair, patient weight capacity up to and including 300 pounds	Prior Authorization Required	Medical Necessity	History and physical, including documentation of medical condition/diagnosis, abilitites and limitations as they relate to the equipment (degree of independence/dependence, frequency, and nature of the activities performed), duration of the medical condition, past experience (if any) using similar equipment, and evaluation of upper extremity strength. medical necessity review will be performed upon claims submission with supporting documentation
K0870	Power wheelchair, group 4 heavy-duty, sling/solid seat/back, patient weight capacity 301 to 450 pounds	Prior Authorization Required	Medical Necessity	History and physical, including documentation of medical condition/diagnosis, abilitites and limitations as they relate to the equipment (degree of independence/dependence, frequency, and nature of the activities performed), duration of the medical condition, past experience (if any) using similar equipment, and evaluation of upper extremity strength. medical necessity review will be performed upon claims submission with supporting documentation

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Code List

Code	Description	Plan Review Requirement	Reviewed For	Records Request
K0871	Power wheelchair, group 4 very heavy-duty, sling/solid seat/back, patient weight capacity 451 to 600 pounds	Prior Authorization Required	Medical Necessity	History and physical, including documentation of medical condition/diagnosis, abilitites and limitations as they relate to the equipment (degree of independence/dependence, frequency, and nature of the activities performed), duration of the medical condition, past experience (if any) using similar equipment, and evaluation of upper extremity strength. medical necessity review will be performed upon claims submission with supporting documentation
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	History and physical, including documentation of medical condition/diagnosis, abilitites and limitations as they relate to the equipment (degree of independence/dependence, frequency, and nature of the activities performed), duration of the medical condition, past experience (if any) using similar equipment, and evaluation of upper extremity strength. medical necessity review will be performed upon claims submission with supporting documentation

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Code List

Code	Description	Plan Review Requirement	Reviewed For	Records Request
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	History and physical, including documentation of medical condition/diagnosis, abilitites and limitations as they relate to the equipment (degree of independence/dependence, frequency, and nature of the activities performed), duration of the medical condition, past experience (if any) using similar equipment, and evaluation of upper extremity strength. medical necessity review will be performed upon claims submission with supporting documentation
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	History and physical, including documentation of medical condition/diagnosis, abilitites and limitations as they relate to the equipment (degree of independence/dependence, frequency, and nature of the activities performed), duration of the medical condition, past experience (if any) using similar equipment, and evaluation of upper extremity strength. medical necessity review will be performed upon claims submission with supporting documentation

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Code List

Code	Description	Plan Review Requirement	Reviewed For	Records Request
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	History and physical, including documentation of medical condition/diagnosis, abilitites and limitations as they relate to the equipment (degree of independence/dependence, frequency, and nature of the activities performed), duration of the medical condition, past experience (if any) using similar equipment, and evaluation of upper extremity strength. medical necessity review will be performed upon claims submission with supporting documentation
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	History and physical, including documentation of medical condition/diagnosis, abilitites and limitations as they relate to the equipment (degree of independence/dependence, frequency, and nature of the activities performed), duration of the medical condition, past experience (if any) using similar equipment, and evaluation of upper extremity strength. medical necessity review will be performed upon claims submission with supporting documentation

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Code List

Code	Description	Plan Review Requirement	Reviewed For	Records Request
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	History and physical, including documentation of medical condition/diagnosis, abilitites and limitations as they relate to the equipment (degree of independence/dependence, frequency, and nature of the activities performed), duration of the medical condition, past experience (if any) using similar equipment, and evaluation of upper extremity strength. medical necessity review will be performed upon claims submission with supporting documentation
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	History and physical, including documentation of medical condition/diagnosis, abilitites and limitations as they relate to the equipment (degree of independence/dependence, frequency, and nature of the activities performed), duration of the medical condition, past experience (if any) using similar equipment, and evaluation of upper extremity strength. medical necessity review will be performed upon claims submission with supporting documentation

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Code List

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	History and physical, including documentation of medical condition/diagnosis, abilitites and limitations as they relate to the equipment (degree of independence/dependence, frequency, and nature of the activities performed), duration of the medical condition, past experience (if any) using similar equipment, and evaluation of upper extremity strength. medical necessity review will be performed upon claims submission with supporting documentation
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	History and physical, including documentation of medical condition/diagnosis, abilitites and limitations as they relate to the equipment (degree of independence/dependence, frequency, and nature of the activities performed), duration of the medical condition, past experience (if any) using similar equipment, and evaluation of upper extremity strength. medical necessity review will be performed upon claims submission with supporting documentation

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Code List

Code	Description	Plan Review Requirement	Reviewed For	Records Request
K0898	Power wheelchair, not otherwise classified	Prior Authorization Required	Medical Necessity	History and physical, including documentation of medical condition/diagnosis, abilitites and limitations as they relate to the equipment (degree of independence/dependence, frequency, and nature of the activities performed), duration of the medical condition, past experience (if any) using similar equipment, and evaluation of upper extremity strength. medical necessity review will be performed upon claims submission with supporting documentation
K0899	Power mobility device, not coded by DME PDAC or does not meet criteria	Prior Authorization Required	Medical Necessity	History and physical, including documentation of medical condition/diagnosis, abilitites and limitations as they relate to the equipment (degree of independence/dependence, frequency, and nature of the activities performed), duration of the medical condition, past experience (if any) using similar equipment, and evaluation of upper extremity strength. medical necessity review will be performed upon claims submission with supporting documentation
K0900	Customized durable medical equipment, other than wheelchair	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
K1004	Low frequency ultrasonic diathermy treatment device for home use	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.

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Code List

Code	Description	Plan Review Requirement	Reviewed For	Records Request
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	Medical necessity review will be performed upon claims submission with supporting documentation	Investigative	History and physical and descripton of equipment
K1030	External recharging system for battery (internal) for use with implanted cardiac contractility modulation generator, replacement only	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	Submit history and physical, documentation of medical necessity and procedure report.
K1035	Molecular diagnostic test reader, nonprescription self-administered and self-collected use, FDA approved, authorized or cleared	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
K1036	Supplies and accessories (eg, transducer) for low frequency ultrasonic diathermy treatment device, per month	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
L0982	Stocking supporter grips, prefabricated, off-the-shelf, set of four (4)	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
L0984	Protective body sock, prefabricated, off-the-shelf, each	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
L0999	Addition to spinal orthosis, not otherwise specified	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	Allow per IHM when billed charge is less than $300. For billed charges greater than $300, submit the description of item provided, and letter of medical necessity including member's current medical condition
L1499	Spinal orthotic, NOS	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	Allow per IHM when billed charge is less than $300. For billed charges greater than $300, submit the description of item provided, and letter of medical necessity including member's current medical condition

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Code List

Code	Description	Plan Review Requirement	Reviewed For	Records Request
L1834	Knee orthotic (KO), without knee joint, rigid, custom fabricated	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	Submit letter of medical necessity including member's medical condition and length of time equipment needed, as well as functional status, if applicable
L1840	Derotation, medial-lateral, anterior cruciate ligament, custom-fabricated	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	Submit letter of medical necessity including member's medical condition and length of time equipment needed, as well as functional status, if applicable
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	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	Submit letter of medical necessity including member's medical condition and length of time equipment needed, as well as functional status, if applicable
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	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	Submit letter of medical necessity including member's medical condition and length of time equipment needed, as well as functional status, if applicable
L1860	Knee orthosis, modification of supracondylar prosthetic socket, custom fabricated (SK)	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	Submit letter of medical necessity including member's medical condition and length of time equipment needed, as well as functional status, if applicable
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	Advance Benefit Determination (ABD) recommended	Investigative	Submit letter of medical necessity including member's medical condition and length of time equipment needed, as well as functional status, if applicable. medical necessity review will be performed upon claims submission with supporting documentation

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Code List

Code	Description	Plan Review Requirement	Reviewed For	Records Request
L2999	Lower extremity orthoses, not otherwise specified	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	Allow per IHM when billed charge is less than $300. For billed charges greater than $300, submit the description of item provided, and letter of medical necessity including member's current medical condition
L3040	Foot, arch support, removable, premolded, longitudinal, each	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
L3050	Foot, arch support, removable, premolded, metatarsal, each	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
L3060	Foot, arch support, removable, premolded, longitudinal/metatarsal, each	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
L3161	Foot, adductus positioning device, adjustable	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L3215	Orthopedic footwear, ladies shoe, Oxford, each	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
L3216	Orthopedic footwear, ladies shoe, depth inlay, each	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
L3217	Orthopedic footwear, ladies shoe, hightop, depth inlay, each	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
L3219	Orthopedic footwear, mens shoe, Oxford, eacH	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
L3221	Orthopedic footwear, mens shoe, depth inlay, each	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
L3222	Orthopedic footwear, mens shoe, hightop, depth inlay, each	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
L3230	Orthopedic footwear, custom shoe, depth inlay, each	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
L3257	Orthopedic footwear, additional charge for split size	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
L3332	Lift, elevation, inside shoe, tapered, up to one-half in	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
L3334	Lift, elevation, heel, per in	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
L3480	Heel, pad and depression for spur	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
L3485	Heel, pad, removable for spur	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
L3500	Orthopedic shoe addition, insole, leathe	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
L3510	Orthopedic shoe addition, insole, rubber	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
L3520	Orthopedic shoe addition, insole, felt covered with leather	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
L3530	Orthopedic shoe addition, sole, half	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
L3540	Orthopedic shoe addition, sole, full	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
L3550	Orthopedic shoe addition, toe tap, standard	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
L3560	Orthopedic shoe addition, toe tap, horseshoe	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
L3570	Orthopedic shoe addition, special extension to instep (leather with eyelets)	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
L3580	Orthopedic shoe addition, convert instep to Velcro closure	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
L3590	Orthopedic shoe addition, convert firm shoe counter to soft counter	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
L3649	Orthopedic shoe, modification, addition or transfer, not otherwise specified	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	Submit letter of medical necessity, including description of the specific shoe modification
L3999	Upper limb orthosis, not otherwise specified	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	Allow per IHM when billed charge is less than $300. For billed charges greater than $300, submit the description of item provided, and letter of medical necessity including member's current medical condition

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
L5000	Partial foot, shoe INSERT with longitudinal arch, toe filler	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L5010	Partial foot, molded socket, ankle height, with toe filler	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L5020	Partial foot, molded socket, tibial tubercle height, with toe filler	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L5050	Ankle, Symes, molded socket, SACH foot	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L5060	Ankle, Symes, metal frame, molded leather socket, articulated ankle/foot (SACH)	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
L5100	Below knee (BK), molded socket, shin, SACH foot	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L5105	Below knee (BK), plastic socket, joints and thigh lacer, SACH foot	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L5150	Knee disarticulation (or through knee), molded socket, external knee joints, shin, SACH foot	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L5160	Knee disarticulation (or through knee), molded socket, bent knee configuration, external knee joints, shin, SACH foot	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L5200	Above knee (AK), molded socket, single axis constant friction knee, shin, SACH foot	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
L5210	Above knee (AK), short prosthesis, no knee joint (stubbies), with foot blocks, no ankle joints, each	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L5220	Above knee (AK), short prosthesis, no knee joint (stubbies), with articulated ankle/foot, dynamically aligned, each	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L5230	Above knee (AK), for proximal femoral focal deficiency, constant friction knee, shin, SACH foot	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L5250	Hip disarticulation, Canadian type; molded socket, hip joint, single axis constant friction knee, shin, SACH foot	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L5270	Hip disarticulation, tilt table type; molded socket, locking hip joint, single axis constant friction knee, shin, SACH foot	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
L5280	Hemipelvectomy, Canadian type; molded socket, hip joint, single axis constant friction knee, shin, SACH foot	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L5301	Below knee (BK), molded socket, shin, SACH foot, endoskeletal system	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L5312	Knee disarticulation (or through knee), molded socket, single axis knee, pylon, SACH foot, endoskeletal system	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L5321	Above knee (AK), molded socket, open end, SACH foot, endoskeletal system, single axis knee	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L5331	Hip disarticulation, Canadian type, molded socket, endoskeletal system, hip joint, single axis knee, SACH foot	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
L5341	Hemipelvectomy, Canadian type, molded socket, endoskeletal system, hip joint, single axis knee, SACH foot	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L5500	Initial, below knee (BK) PTB type socket, nonalignable system, pylon, no cover, SACH foot, plaster socket, direct formed	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L5505	Initial, above knee (AK), knee disarticulation, ischial level socket, nonalignable system, pylon, no cover, SACH foot, plaster socket, direct formed	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L5510	Preparatory, below knee (BK) PTB type socket, nonalignable system, pylon, no cover, SACH foot, plaster socket, molded to model	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L5520	Preparatory, below knee (BK) PTB type socket, nonalignable system, pylon, no cover, SACH foot, thermoplastic or equal, direct formed	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
L5530	Preparatory, below knee (BK) PTB type socket, nonalignable system, pylon, no cover, SACH foot, thermoplastic or equal, molded to model	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L5535	Preparatory, below knee (BK) PTB type socket, nonalignable system, no cover, SACH foot, prefabricated, adjustable open end socket	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L5540	Preparatory, below knee (BK) PTB type socket, nonalignable system, pylon, no cover, SACH foot, laminated socket, molded to model	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L5560	Preparatory, above knee (AK), knee disarticulation, ischial level socket, nonalignable system, pylon, no cover, SACH foot, plaster socket, molded to model	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L5570	Preparatory, above knee (AK), knee disarticulation, ischial level socket, nonalignable system, pylon, no cover, SACH foot, thermoplastic or equal, direct formed	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
L5580	Preparatory, above knee (AK), knee disarticulation, ischial level socket, nonalignable system, pylon, no cover, SACH foot, thermoplastic or equal, molded to model	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L5585	Preparatory, above knee (AK), knee disarticulation, ischial level socket, nonalignable system, pylon, no cover, SACH foot, prefabricated adjustable open end socket	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L5590	Preparatory, above knee (AK), knee disarticulation, ischial level socket, nonalignable system, pylon, no cover, SACH foot, laminated socket, molded to model	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L5595	Preparatory, hip disarticulation/hemipelvectomy, pylon, no cover, SACH foot, thermoplastic or equal, molded to patient model	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L5600	Preparatory, hip disarticulation/hemipelvectomy, pylon, no cover, SACH foot, laminated socket, molded to patient model	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
L5610	Addition to lower extremity, endoskeletal system, above knee (AK), hydracadence system	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L5611	Addition to lower extremity, endoskeletal system, above knee (AK), knee disarticulation, four-bar linkage, with friction swing phase control	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L5613	Addition to lower extremity, endoskeletal system, above knee (AK), knee disarticulation, four-bar linkage, with hydraulic swing phase control	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L5614	Addition to lower extremity, exoskeletal system, above knee (AK), knee disarticulation, four-bar linkage, with pneumatic swing phase control	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (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	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
L5616	Addition to lower extremity, endoskeletal system, above knee (AK), universal multiplex system, friction swing phase control	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L5617	Addition to lower extremity, quick change self-aligning unit, above knee (AK) or below knee (BK), each	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L5618	Addition to lower extremity, test socket, Symes	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L5620	Addition to lower extremity, test socket, below knee (BK)	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L5622	Addition to lower extremity, test socket, knee disarticulation	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
L5624	Addition to lower extremity, test socket, above knee (AK)	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L5626	Addition to lower extremity, test socket, hip disarticulation	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L5628	Addition to lower extremity, test socket, hemipelvectomy	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L5629	Addition to lower extremity, below knee, acrylic socket	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L5630	Addition to lower extremity, Symes type, expandable wall socket	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
L5631	Addition to lower extremity, above knee (AK) or knee disarticulation, acrylic socket	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L5632	Addition to lower extremity, Symes type, PTB brim design socket	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L5634	Addition to lower extremity, Symes type, posterior opening (Canadian) socket	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L5636	Addition to lower extremity, Symes type, medial opening socket	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L5637	Addition to lower extremity, below knee (BK), total contact	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
L5638	Addition to lower extremity, below knee (BK), leather socket	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L5639	Addition to lower extremity, below knee (BK), wood socket	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L5640	Addition to lower extremity, knee disarticulation, leather socket	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L5642	Addition to lower extremity, above knee (AK), leather socket	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L5643	Addition to lower extremity, hip disarticulation, flexible inner socket, external frame	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
L5644	Addition to lower extremity, above knee (AK), wood socket	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L5645	Addition to lower extremity, below knee (BK), flexible inner socket, external frame	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L5646	Addition to lower extremity, below knee (BK), air, fluid, gel or equal, cushion socket	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L5647	Addition to lower extremity, below knee (BK), suction socket	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L5648	Addition to lower extremity, above knee (AK), air, fluid, gel or equal, cushion socket	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition

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Code List

Code	Description	Plan Review Requirement	Reviewed For	Records Request
L5649	Addition to lower extremity, ischial containment/narrow M-L socket	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L5650	Additions to lower extremity, total contact, above knee (AK) or knee disarticulation socket	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L5651	Addition to lower extremity, above knee (AK), flexible inner socket, external frame	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L5652	Addition to lower extremity, suction suspension, above knee (AK) or knee disarticulation socket	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L5653	Addition to lower extremity, knee disarticulation, expandable wall socket	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition

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Code List

Code	Description	Plan Review Requirement	Reviewed For	Records Request
L5654	Addition to lower extremity, socket INSERT, Symes, (Kemblo, Pelite, Aliplast, Plastazote or equal)	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L5655	Addition to lower extremity, socket INSERT, below knee (BK) (Kemblo, Pelite, Aliplast, Plastazote or equal)	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L5656	Addition to lower extremity, socket INSERT, knee disarticulation (Kemblo, Pelite, Aliplast, Plastazote or equal)	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L5658	Addition to lower extremity, socket INSERT, above knee (AK) (Kemblo, Pelite, Aliplast, Plastazote or equal)	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L5661	Addition to lower extremity, socket INSERT, multidurometer Symes	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition

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Code List

Code	Description	Plan Review Requirement	Reviewed For	Records Request
L5665	Addition to lower extremity, socket INSERT, multidurometer, below knee (BK)	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L5666	Addition to lower extremity, below knee (BK), cuff suspension	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L5668	Addition to lower extremity, below knee (BK), molded distal cushion	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L5670	Addition to lower extremity, below knee (BK), molded supracondylar suspension (PTS or similar)	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L5671	Addition to lower extremity, below knee (BK)/above knee (AK) suspension locking mechanism (shuttle, lanyard, or equal), excludes socket INSERT	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition

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Code List

Code	Description	Plan Review Requirement	Reviewed For	Records Request
L5672	Addition to lower extremity, below knee (BK), removable medial brim suspension	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L5673	Addition to lower extremity, below knee (BK)/above knee (AK), custom fabricated from existing mold or prefabricated, socket INSERT, silicone gel, elastomeric or equal, for use with locking mechanism	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L5676	Additions to lower extremity, below knee (BK), knee joints, single axis, pair	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L5677	Additions to lower extremity, below knee (BK), knee joints, polycentric, pair	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L5678	Additions to lower extremity, below knee (BK), joint covers, pair	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition

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Code List

Code	Description	Plan Review Requirement	Reviewed For	Records Request
L5679	Addition to lower extremity, below knee (BK)/above knee (AK), custom fabricated from existing mold or prefabricated, socket INSERT, silicone gel, elastomeric or equal, not for use with locking mechanism	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L5680	Addition to lower extremity, below knee (BK), thigh lacer, nonmolded	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L5681	Addition to lower extremity, below knee (BK)/above knee (AK), custom fabricated socket INSERT for congenital or atypical traumatic amputee, silicone gel, elastomeric or equal, for use with or without locking mechanism, initial only (for other than initial, use code L5673 or L5679	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L5682	Addition to lower extremity, below knee (BK), thigh lacer, gluteal/ischial, molded	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L5683	Addition to lower extremity, below knee (BK)/above knee (AK), custom fabricated socket INSERT for other than congenital or atypical traumatic amputee, silicone gel, elastomeric or equal, for use with or without locking mechanism, initial only (for other than initial, use code L5673 or L5679)	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition

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Code List

Code	Description	Plan Review Requirement	Reviewed For	Records Request
L5684	Addition to lower extremity, below knee, fork strap	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L5685	Addition to lower extremity prosthesis, below knee, suspension/sealing sleeve, with or without valve, any material, each	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L5686	Addition to lower extremity, below knee (BK), back check (extension control)	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L5688	Addition to lower extremity, below knee (BK), waist belt, webbing	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L5690	Addition to lower extremity, below knee (BK), waist belt, padded and lined	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition

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Code List

Code	Description	Plan Review Requirement	Reviewed For	Records Request
L5692	Addition to lower extremity, above knee (AK), pelvic control belt, light	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L5694	Addition to lower extremity, above knee (AK), pelvic control belt, padded and lined	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L5695	Addition to lower extremity, above knee (AK), pelvic control, sleeve suspension, neoprene or equal, each	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L5696	Addition to lower extremity, above knee (AK) or knee disarticulation, pelvic joint	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L5697	Addition to lower extremity, above knee (AK) or knee disarticulation, pelvic band	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition

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Code List

Code	Description	Plan Review Requirement	Reviewed For	Records Request
L5698	Addition to lower extremity, above knee (AK) or knee disarticulation, Silesian bandage	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L5699	All lower extremity prostheses, shoulder harness	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L5700	Replacement, socket, below knee (BK), molded to patient model	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L5701	Replacement, socket, above knee (AK)/knee disarticulation, including attachment plate, molded to patient model	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L5702	Replacement, socket, hip disarticulation, including hip joint, molded to patient model	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
L5703	Ankle, Symes, molded to patient model, socket without solid ankle cushion heel (SACH) foot, replacement only	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L5704	Custom shaped protective cover, below knee (BK)	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L5705	Custom shaped protective cover, above knee (AK)	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L5706	Custom shaped protective cover, knee disarticulation	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L5707	Custom shaped protective cover, hip disarticulation	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition

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Code List

Code	Description	Plan Review Requirement	Reviewed For	Records Request
L5710	Addition, exoskeletal knee-shin system, single axis, manual lock	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L5711	Additions exoskeletal knee-shin system, single axis, manual lock, ultra-light material	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L5712	Addition, exoskeletal knee-shin system, single axis, friction swing and stance phase control (safety knee)	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L5714	Addition, exoskeletal knee-shin system, single axis, variable friction swing phase control	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L5716	Addition, exoskeletal knee-shin system, polycentric, mechanical stance phase lock	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
L5718	Addition, exoskeletal knee-shin system, polycentric, friction swing and stance phase control	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L5722	Addition, exoskeletal knee-shin system, single axis, pneumatic swing, friction stance phase control	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L5724	Addition, exoskeletal knee-shin system, single axis, fluid swing phase control	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L5726	Addition, exoskeletal knee-shin system, single axis, external joints, fluid swing phase control	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L5728	Addition, exoskeletal knee-shin system, single axis, fluid swing and stance phase control	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
L5780	Addition, exoskeletal knee-shin system, single axis, pneumatic/hydra pneumatic swing phase control	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L5781	Addition to lower limb prosthesis, vacuum pump, residual limb volume management and moisture evacuation system	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L5782	Addition to lower limb prosthesis, vacuum pump, residual limb volume management and moisture evacuation system, heavy-duty	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L5785	Addition, exoskeletal system, below knee (BK), ultra-light material (titanium, carbon fiber or equal)	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L5790	Addition, exoskeletal system, above knee (AK), ultra-light material (titanium, carbon fiber or equal)	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
L5795	Addition, exoskeletal system, hip disarticulation, ultra-light material (titanium, carbon fiber or equal)	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L5810	Addition, endoskeletal knee-shin system, single axis, manual lock	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L5811	Addition, endoskeletal knee-shin system, single axis, manual lock, ultra-light material	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L5812	Addition, endoskeletal knee-shin system, single axis, friction swing and stance phase control (safety knee)	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L5814	Addition, endoskeletal knee-shin system, polycentric, hydraulic swing phase control, mechanical stance phase lock	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
L5816	Addition, endoskeletal knee-shin system, polycentric, mechanical stance phase lock	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L5818	Addition, endoskeletal knee-shin system, polycentric, friction swing and stance phase control	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L5822	Addition, endoskeletal knee-shin system, single axis, pneumatic swing, friction stance phase control	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L5824	Addition, endoskeletal knee-shin system, single axis, fluid swing phase control	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L5826	Addition, endoskeletal knee-shin system, single axis, hydraulic swing phase control, with miniature high activity frame	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
L5827	Endoskeletal knee-shin system, single axis, electromechanical swing and stance phase control, with or without shock absorption and stance extension damping	Medical necessity review will be performed upon claims submission with supporting documentation	Investigative	Submit history and physical, documentation of medical necessity.
L5828	Addition, endoskeletal knee-shin system, single axis, fluid swing and stance phase control	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L5830	Addition, endoskeletal knee-shin system, single axis, pneumatic/swing phase control	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L5840	Addition, endoskeletal knee-shin system, four-bar linkage or multiaxial, pneumatic swing phase control	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L5845	Addition, endoskeletal knee-shin system, stance flexion feature, adjustable	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
L5848	Addition to endoskeletal knee-shin system, fluid stance extension, dampening feature, with or without adjustability	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L5850	Addition, endoskeletal system, above knee (AK) or hip disarticulation, knee extension assist	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L5855	Addition, endoskeletal system, hip disarticulation, mechanical hip extension assist	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
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	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition. medical necessity review will be performed upon claims submission with supporting documentation

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Code List

Code	Description	Plan Review Requirement	Reviewed For	Records Request
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	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition. medical necessity review will be performed upon claims submission with supporting documentation
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	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition. medical necessity review will be performed upon claims submission with supporting documentation
L5859	Addition to lower extremity prosthesis, endoskeletal knee-shin system, powered and programmable flexion/extension assist control, includes any type motor(s)	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition. medical necessity review will be performed upon claims submission with supporting documentation
L5910	Addition, endoskeletal system, below knee (BK), alignable system	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition

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Code List

Code	Description	Plan Review Requirement	Reviewed For	Records Request
L5920	Addition, endoskeletal system, above knee (AK) or hip disarticulation, alignable system	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L5925	Addition, endoskeletal system, above knee (AK), knee disarticulation or hip disarticulation, manual lock	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L5926	Addition to lower extremity prosthesis, endoskeletal, knee disarticulation, above knee, hip disarticulation, positional rotation unit, any type	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L5930	Addition, endoskeletal system, high activity knee control frame	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L5940	Addition, endoskeletal system, below knee (BK), ultra-light material (titanium, carbon fiber or equal)	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition

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Code List

Code	Description	Plan Review Requirement	Reviewed For	Records Request
L5950	Addition, endoskeletal system, above knee (AK), ultra-light material (titanium, carbon fiber or equal)	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L5960	Addition, endoskeletal system, hip disarticulation, ultra-light material (titanium, carbon fiber or equal)	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L5961	Addition, endoskeletal system, polycentric hip joint, pneumatic or hydraulic control, rotation control, with or without flexion and/or extension control	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L5962	Addition, endoskeletal system, below knee (BK), flexible protective outer surface covering system	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L5964	Addition, endoskeletal system, above knee (AK), flexible protective outer surface covering system	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition

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Code List

Code	Description	Plan Review Requirement	Reviewed For	Records Request
L5966	Addition, endoskeletal system, hip disarticulation, flexible protective outer surface covering system	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L5968	Addition to lower limb prosthesis, multiaxial ankle with swing phase active dorsiflexion feature	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L5969	Addition, endoskeletal ankle-foot or ankle system, power assist, includes any type motor(s)	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L5970	All lower extremity prostheses, foot, external keel, SACH foot	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L5971	All lower extremity prostheses, solid ankle cushion heel (SACH) foot, replacement only	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition

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Code List

Code	Description	Plan Review Requirement	Reviewed For	Records Request
L5972	All lower extremity prostheses, foot, flexible keel	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L5973	Endoskeletal ankle foot system, microprocessor controlled feature, dorsiflexion and/or plantar flexion control, includes power source	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition. medical necessity review will be performed upon claims submission with supporting documentation
L5974	All lower extremity prostheses, foot, single axis ankle/foot	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L5975	All lower extremity prostheses, combination single axis ankle and flexible keel foot	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L5976	All lower extremity prostheses, energy storing foot (Seattle Carbon Copy II or equal)	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition

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Code List

Code	Description	Plan Review Requirement	Reviewed For	Records Request
L5978	All lower extremity prostheses, foot, multiaxial ankle/foot	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L5979	All lower extremity prostheses, multiaxial ankle, dynamic response foot, one-piece system	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L5980	All lower extremity prostheses, flex-foot system	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L5981	All lower extremity prostheses, flex-walk system or equal	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L5982	All exoskeletal lower extremity prostheses, axial rotation unit	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
L5984	All endoskeletal lower extremity prostheses, axial rotation unit, with or without adjustability	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L5985	All endoskeletal lower extremity prostheses, dynamic prosthetic pylon	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L5986	All lower extremity prostheses, multiaxial rotation unit (MCP or equal)	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L5987	All lower extremity prostheses, shank foot system with vertical loading pylon	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L5988	Addition to lower limb prosthesis, vertical shock reducing pylon feature	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition

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Code List

Code	Description	Plan Review Requirement	Reviewed For	Records Request
L5990	Addition to lower extremity prosthesis, user adjustable heel height	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L5991	Addition to lower extremity prosthesis, osseointegrated external prosthetic connector	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L5999	Lower extremity prosthesis, not otherwise specified	Prior Authorization Required	Medical Necessity	Allow per IHM when billed charge is less than $300. For billed charges greater than $300, submit the description of item provided, and letter of medical necessity including member's current medical condition
L6000	Partial hand, thumb remaining	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L6010	Partial hand, little and/or ring finger remaining	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition

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L6020	Partial hand, no finger remaining	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
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/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition. medical necessity review will be performed upon claims submission with supporting documentation
L6050	Wrist disarticulation, molded socket, flexible elbow hinges, triceps pad	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L6055	Wrist disarticulation, molded socket with expandable interface, flexible elbow hinges, triceps pad	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L6100	Below elbow, molded socket, flexible elbow hinge, triceps pad	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
L6110	Below elbow, molded socket (Muenster or Northwestern suspension types)	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L6120	Below elbow, molded double wall split socket, step-up hinges, half cuff	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L6130	Below elbow, molded double wall split socket, stump activated locking hinge, half cuff	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L6200	Elbow disarticulation, molded socket, outside locking hinge, forearm	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L6205	Elbow disarticulation, molded socket with expandable interface, outside locking hinges, forearm	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
L6250	Above elbow, molded double wall socket, internal locking elbow, forearm	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L6300	Shoulder disarticulation, molded socket, shoulder bulkhead, humeral section, internal locking elbow, forearm	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L6310	Shoulder disarticulation, passive restoration (complete prosthesis)	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L6320	Shoulder disarticulation, passive restoration (shoulder cap only)	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L6350	Interscapular thoracic, molded socket, shoulder bulkhead, humeral section, internal locking elbow, forearm	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
L6360	Interscapular thoracic, passive restoration (complete prosthesis)	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L6370	Interscapular thoracic, passive restoration (shoulder cap only)	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L6380	Immediate postsurgical or early fitting, application of initial rigid dressing, including fitting alignment and suspension of components, and one cast change, wrist disarticulation or below elbow	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L6382	Immediate postsurgical or early fitting, application of initial rigid dressing including fitting alignment and suspension of components, and one cast change, elbow disarticulation or above elbow	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L6384	Immediate postsurgical or early fitting, application of initial rigid dressing including fitting alignment and suspension of components, and one cast change, shoulder disarticulation or interscapular thoracic	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
L6386	Immediate postsurgical or early fitting, each additional cast change and realignment	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L6388	Immediate postsurgical or early fitting, application of rigid dressing only	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L6400	Below elbow, molded socket, endoskeletal system, including soft prosthetic tissue shaping	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L6450	Elbow disarticulation, molded socket, endoskeletal system, including soft prosthetic tissue shaping	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L6500	Above elbow, molded socket, endoskeletal system, including soft prosthetic tissue shaping	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
L6550	Shoulder disarticulation, molded socket, endoskeletal system, including soft prosthetic tissue shaping	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L6570	Interscapular thoracic, molded socket, endoskeletal system, including soft prosthetic tissue shaping	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L6580	Preparatory, wrist disarticulation or below elbow, single wall plastic socket, friction wrist, flexible elbow hinges, figure of eight harness, humeral cuff, Bowden cable control, USMC or equal pylon, no cover, molded to patient model	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L6582	Preparatory, wrist disarticulation or below elbow, single wall socket, friction wrist, flexible elbow hinges, figure of eight harness, humeral cuff, Bowden cable control, USMC or equal pylon, no cover, direct formed	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L6584	Preparatory, elbow disarticulation or above elbow, single wall plastic socket, friction wrist, locking elbow, figure of eight harness, fair lead cable control, USMC or equal pylon, no cover, molded to patient model	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition

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L6586	Preparatory, elbow disarticulation or above elbow, single wall socket, friction wrist, locking elbow, figure of eight harness, fair lead cable control, USMC or equal pylon, no cover, direct formed	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L6588	Preparatory, shoulder disarticulation or interscapular thoracic, single wall plastic socket, shoulder joint, locking elbow, friction wrist, chest strap, fair lead cable control, USMC or equal pylon, no cover, molded to patient model	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L6590	Preparatory, shoulder disarticulation or interscapular thoracic, single wall socket, shoulder joint, locking elbow, friction wrist, chest strap, fair lead cable control, USMC or equal pylon, no cover, direct formed	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L6600	Upper extremity additions, polycentric hinge, pair	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L6605	Upper extremity additions, single pivot hinge, pair	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
L6610	Upper extremity additions, flexible metal hinge, pair	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L6611	Addition to upper extremity prosthesis, external powered, additional switch, any type	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L6615	Upper extremity addition, disconnect locking wrist unit	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L6616	Upper extremity addition, additional disconnect INSERT for locking wrist unit, each	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L6620	Upper extremity addition, flexion/extension wrist unit, with or without friction	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
L6621	Upper extremity prosthesis addition, flexion/extension wrist with or without friction, for use with external powered terminal device	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L6623	Upper extremity addition, spring assisted rotational wrist unit with latch release	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L6624	Upper extremity addition, flexion/extension and rotation wrist unit	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L6625	Upper extremity addition, rotation wrist unit with cable lock	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L6628	Upper extremity addition, quick disconnect hook adapter, Otto Bock or equal	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
L6629	Upper extremity addition, quick disconnect lamination collar with coupling piece, Otto Bock or equal	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L6630	Upper extremity addition, stainless steel, any wrist	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L6632	Upper extremity addition, latex suspension sleeve, each	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L6635	Upper extremity addition, lift assist for elbow	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L6637	Upper extremity addition, nudge control elbow lock	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition

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Code List

Code	Description	Plan Review Requirement	Reviewed For	Records Request
L6638	Upper extremity addition to prosthesis, electric locking feature, only for use with manually powered elbow	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L6640	Upper extremity additions, shoulder abduction joint, pair	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L6641	Upper extremity addition, excursion amplifier, pulley type	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L6642	Upper extremity addition, excursion amplifier, lever type	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L6645	Upper extremity addition, shoulder flexion-abduction joint, each	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition

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Code List

Code	Description	Plan Review Requirement	Reviewed For	Records Request
L6646	Upper extremity addition, shoulder joint, multipositional locking, flexion, adjustable abduction friction control, for use with body powered or external powered system	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L6647	Upper extremity addition, shoulder lock mechanism, body powered actuator	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L6648	Upper extremity addition, shoulder lock mechanism, external powered actuator	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L6650	Upper extremity addition, shoulder universal joint, each	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L6655	Upper extremity addition, standard control cable, extra	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition

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Code List

Code	Description	Plan Review Requirement	Reviewed For	Records Request
L6660	Upper extremity addition, heavy-duty control cable	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L6665	Upper extremity addition, Teflon, or equal, cable lining	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L6670	Upper extremity addition, hook to hand, cable adapter	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L6672	Upper extremity addition, harness, chest or shoulder, saddle type	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L6675	Upper extremity addition, harness, (e.g., figure of eight type), single cable design	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition

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Code List

Code	Description	Plan Review Requirement	Reviewed For	Records Request
L6676	Upper extremity addition, harness, (e.g., figure of eight type), dual cable design	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L6677	Upper extremity addition, harness, triple control, simultaneous operation of terminal device and elbow	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L6680	Upper extremity addition, test socket, wrist disarticulation or below elbow	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L6682	Upper extremity addition, test socket, elbow disarticulation or above elbow	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L6684	Upper extremity addition, test socket, shoulder disarticulation or interscapular thoracic	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition

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Code List

Code	Description	Plan Review Requirement	Reviewed For	Records Request
L6686	Upper extremity addition, suction socket	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L6687	Upper extremity addition, frame type socket, below elbow or wrist disarticulation	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L6688	Upper extremity addition, frame type socket, above elbow or elbow disarticulation	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L6689	Upper extremity addition, frame type socket, shoulder disarticulation	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L6690	Upper extremity addition, frame type socket, interscapular-thoracic	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition

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Code List

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L6691	Upper extremity addition, removable INSERT, each	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L6692	Upper extremity addition, silicone gel INSERT or equal, with or without locking mechanism, each	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L6693	Upper extremity addition, locking elbow, forearm counterbalance	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L6694	Addition to upper extremity prosthesis, below elbow/above elbow, custom fabricated from existing mold or prefabricated, socket INSERT, silicone gel, elastomeric or equal, for use with locking mechanism	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L6695	Addition to upper extremity prosthesis, below elbow/above elbow, custom fabricated from existing mold or prefabricated, socket INSERT, silicone gel, elastomeric or equal, not for use with locking mechanism	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition

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Code List

Code	Description	Plan Review Requirement	Reviewed For	Records Request
L6696	Addition to upper extremity prosthesis, below elbow/above elbow, custom fabricated socket INSERT for congenital or atypical traumatic amputee, silicone gel, elastomeric or equal, for use with or without locking mechanism, initial only (for other than initial, use code L6694 or L6695)	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L6697	Addition to upper extremity prosthesis, below elbow/above elbow, custom fabricated socket INSERT for other than congenital or atypical traumatic amputee, silicone gel, elastomeric or equal, for use with or without locking mechanism, initial only (for other than initial, use code L6694 or L6695)	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L6698	Addition to upper extremity prosthesis, lock mechanism, excludes socket INSERT	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L6700	Upper extremity addition, external powered feature, myoelectronic control module, additional emg inputs, pattern-recognition decoding intent movement	Medical necessity review will be performed upon claims submission with supporting documentation	Investigative	Submit history and physical, documentation of medical necessity.
L6703	Terminal device, passive hand/mitt, any material, any size	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition

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Code List

Code	Description	Plan Review Requirement	Reviewed For	Records Request
L6704	Terminal device, sport/recreational/work attachment, any material, any size	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L6706	Terminal device, hook, mechanical, voluntary opening, any material, any size, lined or unlined	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L6707	Terminal device, hook, mechanical, voluntary closing, any material, any size, lined or unlined	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L6708	Terminal device, hand, mechanical, voluntary opening, any material, any size	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L6709	Terminal device, hand, mechanical, voluntary closing, any material, any size	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
L6711	Terminal device, hook, mechanical, voluntary opening, any material, any size, lined or unlined, pediatric	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L6712	Terminal device, hook, mechanical, voluntary closing, any material, any size, lined or unlined, pediatric	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L6713	Terminal device, hand, mechanical, voluntary opening, any material, any size, pediatric	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L6714	Terminal device, hand, mechanical, voluntary closing, any material, any size, pediatric	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L6715	Terminal device, multiple articulating digit, includes motor(s), initial issue or replacement	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition. medical necessity review will be performed upon claims submission with supporting documentation

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Code List

Code	Description	Plan Review Requirement	Reviewed For	Records Request
L6721	Terminal device, hook or hand, heavy-duty, mechanical, voluntary opening, any material, any size, lined or unlined	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L6722	Terminal device, hook or hand, heavy-duty, mechanical, voluntary closing, any material, any size, lined or unlined	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L6805	Addition to terminal device, modifier wrist unit	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L6810	Addition to terminal device, precision pinch device	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
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, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition. medical necessity review will be performed upon claims submission with supporting documentation

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Code List

Code	Description	Plan Review Requirement	Reviewed For	Records Request
L6881	Automatic grasp feature, addition to upper limb electric prosthetic terminal device	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L6882	Microprocessor control feature, addition to upper limb prosthetic terminal device	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L6883	Replacement socket, below elbow/wrist disarticulation, molded to patient model, for use with or without external power	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L6884	Replacement socket, above elbow/elbow disarticulation, molded to patient model, for use with or without external power	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L6885	Replacement socket, shoulder disarticulation/interscapular thoracic, molded to patient model, for use with or without external power	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition

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Code List

Code	Description	Plan Review Requirement	Reviewed For	Records Request
L6890	Addition to upper extremity prosthesis, glove for terminal device, any material, prefabricated, includes fitting and adjustment	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L6895	Addition to upper extremity prosthesis, glove for terminal device, any material, custom fabricated	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L6900	Hand restoration (casts, shading and measurements included), partial hand, with glove, thumb or one finger remaining	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L6905	Hand restoration (casts, shading and measurements included), partial hand, with glove, multiple fingers remaining	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L6910	Hand restoration (casts, shading and measurements included), partial hand, with glove, no fingers remaining	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
L6915	Hand restoration (shading and measurements included), replacement glove for above	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L6920	Wrist disarticulation, external power, self-suspended inner socket, removable forearm shell, Otto Bock or equal switch, cables, two batteries and one charger, switch control of terminal device	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
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/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition. medical necessity review will be performed upon claims submission with supporting documentation
L6930	Below elbow, external power, self-suspended inner socket, removable forearm shell, Otto Bock or equal switch, cables, two batteries and one charger, switch control of terminal device	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
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/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition. medical necessity review will be performed upon claims submission with supporting documentation
L6940	Elbow disarticulation, external power, molded inner socket, removable humeral shell, outside locking hinges, forearm, Otto Bock or equal switch, cables, two batteries and one charger, switch control of terminal device	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
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/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition. medical necessity review will be performed upon claims submission with supporting documentation
L6950	Above elbow, external power, molded inner socket, removable humeral shell, internal locking elbow, forearm, Otto Bock or equal switch, cables, two batteries and one charger, switch control of terminal device	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
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/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition. medical necessity review will be performed upon claims submission with supporting documentation
L6960	Shoulder disarticulation, external power, molded inner socket, removable shoulder shell, shoulder bulkhead, humeral section, mechanical elbow, forearm, Otto Bock or equal switch, cables, two batteries and one charger, switch control of terminal device	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
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/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition. medical necessity review will be performed upon claims submission with supporting documentation
L6970	Interscapular-thoracic, external power, molded inner socket, removable shoulder shell, shoulder bulkhead, humeral section, mechanical elbow, forearm, Otto Bock or equal switch, cables, two batteries and one charger, switch control of terminal device	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition

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L6975	Interscapular-thoracic, external power, molded inner socket, removable shoulder shell, shoulder bulkhead, humeral section, mechanical elbow, forearm, Otto Bock or equal electrodes, cables, 2 batteries and one charger, myoelectronic control of terminal device	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition. medical necessity review will be performed upon claims submission with supporting documentation
L7007	Electric hand, switch or myoelectric controlled, adult	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition. medical necessity review will be performed upon claims submission with supporting documentation
L7008	Electric hand, switch or myoelectric, controlled, pediatric	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition. medical necessity review will be performed upon claims submission with supporting documentation
L7009	Electric hook, switch or myoelectric controlled, adult	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition. medical necessity review will be performed upon claims submission with supporting documentation

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Code List

Code	Description	Plan Review Requirement	Reviewed For	Records Request
L7040	Prehensile actuator, switch controlled	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L7045	Electric hook, switch or myoelectric controlled, pediatric	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition. medical necessity review will be performed upon claims submission with supporting documentation
L7170	Electronic elbow, Hosmer or equal, switch controlled	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L7180	Electronic elbow, microprocessor sequential control of elbow and terminal device	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
L7181	Electronic elbow, microprocessor simultaneous control of elbow and terminal device	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition. medical necessity review will be performed upon claims submission with supporting documentation
L7185	Electronic elbow, adolescent, Variety Village or equal, switch controlled	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L7186	Electronic elbow, child, Variety Village or equal, switch controlled	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L7190	Electronic elbow, adolescent, Variety Village or equal, myoelectronically controlled	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition. medical necessity review will be performed upon claims submission with supporting documentation

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Code List

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L7191	Electronic elbow, child, Variety Village or equal, myoelectronically controlled	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition. medical necessity review will be performed upon claims submission with supporting documentation
L7259	Electronic wrist rotator, any type	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition. medical necessity review will be performed upon claims submission with supporting documentation
L7400	Addition to upper extremity prosthesis, below elbow/wrist disarticulation, ultra-light material (titanium, carbon fiber or equal)	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L7401	Addition to upper extremity prosthesis, above elbow disarticulation, ultra-light material (titanium, carbon fiber or equal)	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition

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Code List

Code	Description	Plan Review Requirement	Reviewed For	Records Request
L7402	Addition to upper extremity prosthesis, shoulder disarticulation/interscapular thoracic, ultra-light material (titanium, carbon fiber or equal)	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L7403	Addition to upper extremity prosthesis, below elbow/wrist disarticulation, acrylic material	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L7404	Addition to upper extremity prosthesis, above elbow disarticulation, acrylic material	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L7405	Addition to upper extremity prosthesis, shoulder disarticulation/interscapular thoracic, acrylic material	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L7499	Upper extremity prosthesis, not otherwise specified	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition

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Code List

Code	Description	Plan Review Requirement	Reviewed For	Records Request
L7510	Repair of prosthetic device, repair or replace minor parts	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L7520	Repair prosthetic device, labor component, per 15 minutes	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L7600	Prosthetic donning sleeve, any material, each	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L7700	Gasket or seal, for use with prosthetic socket INSERT, any type, each	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L7900	Male vacuum erection system	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
L7902	Tension ring, for vacuum erection device, any type, replacement only, each	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.

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Code List

Code	Description	Plan Review Requirement	Reviewed For	Records Request
L8000	Breast prosthesis, mastectomy bra, without integrated breast prosthesis form, any size, any type	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L8001	Breast prosthesis, mastectomy bra, with integrated breast prosthesis form, unilateral, any size, any type	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L8002	Breast prosthesis, mastectomy bra, with integrated breast prosthesis form, bilateral, any size, any type	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L8015	External breast prosthesis garment, with mastectomy form, post mastectomy	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L8020	Breast prosthesis, mastectomy form	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
L8030	Breast prosthesis, silicone or equal, without integral adhesive, any type	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L8031	Breast prosthesis, silicone or equal, with integral adhesive, any type	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L8032	Nipple prosthesis, prefabricated, reusable, any type, each	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L8033	Nipple prosthesis, custom fabricated, reusable, any material, any type, each	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L8035	Custom breast prosthesis, post mastectomy, molded to patient model, any type	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
L8039	Breast prosthesis, not otherwise specified	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L8040	Nasal prosthesis, provided by a nonphysician	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L8041	Midfacial prosthesis, provided by a nonphysician	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L8042	Orbital prosthesis, provided by a nonphysician	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L8043	Upper facial prosthesis, provided by a nonphysician	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
L8044	Hemi-facial prosthesis, provided by a nonphysician	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L8045	Auricular prosthesis, provided by a nonphysician	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L8046	Partial facial prosthesis, provided by a nonphysician	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L8047	Nasal septal prosthesis, provided by a nonphysician	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L8048	Unspecified maxillofacial prosthesis, by report, provided by a nonphysician	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition

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L8049	Repair or modification of maxillofacial prosthesis, labor component, 15 minute increments, provided by a nonphysician	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L8499	Unlisted procedure for miscellaneous prosthetic services	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	Submit letter of medical necessity from ordering procuder, including a description of the item and manufacturer cost invoice
L8600	Implantable breast prosthesis, silicone or equal	Prior Authorization Required	Potential Contract Exclusion	For gender affirming surgery: Submit history and physical, documentation of gender dysphoria and any hormone therapy, as well as written psychological assessment from a qualified mental health provider. For non-gender affirming surgery: Submit history and physical, pre-operative evaluation, including functional impairment and operative report. Medical necessity review will be performed upon claims submission with supporting documentation
L8604	Injectable bulking agent, dextranomer/hyaluronic acid copolymer implant, urinary tract, 1 ml, includes shipping and necessary supplies	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	Submit history and physical, documentation of medical necessity and procedure report.
L8605	Injectable bulking agent, dextranomer/hyaluronic acid copolymer implant, anal canal, 1 ml, includes shipping and necessary supplies	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	Submit history and physical, documentation of medical necessity and procedure report.
L8607	Injectable bulking agent for vocal cord medialization, 0.1 ml, includes shipping and necessary supplies	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
L8608	Miscellaneous external component, supply or accessory for use with the Argus II Retinal Prosthesis System	Prior Authorization Required	Investigative	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition
L8609	Artificial cornea	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical and prosthesis type
L8614	Cochlear device, includes all internal and external components	Prior Authorization Required	Medical Necessity	History and physical, operative report, and audiology report with hearing thresholds. medical necessity review will be performed upon claims submission with supporting documentation
L8615	Headset/headpiece for use with cochlear implant device, replacement	Prior Authorization Required	Medical Necessity	History and physical, operative report, and audiology report with hearing thresholds
L8616	Microphone for use with cochlear implant device, replacement	Prior Authorization Required	Medical Necessity	History and physical, operative report, and audiology report with hearing thresholds
L8617	Transmitting coil for use with cochlear implant device, replacement	Prior Authorization Required	Medical Necessity	History and physical, operative report, and audiology report with hearing thresholds
L8618	Transmitter cable for use with cochlear implant device or auditory osseointegrated device, replacement	Prior Authorization Required	Medical Necessity	History and physical, operative report, and audiology report with hearing thresholds
L8619	Cochlear implant external speech processor, replacement	Prior Authorization Required	Medical Necessity	History and physical, operative report, and audiology report with hearing thresholds. medical necessity review will be performed upon claims submission with supporting documentation

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L8627	Cochlear implant, external speech processor, component, replacement	Prior Authorization Required	Medical Necessity	History and physical, operative report, and audiology report with hearing thresholds
L8628	Cochlear implant, external controller component, replacement	Prior Authorization Required	Medical Necessity	History and physical, operative report, and audiology report with hearing thresholds
L8641	Metatarsal joint implant	Medical necessity review will be performed upon claims submission with supporting documentation	Investigative	Submit history and physical, documentation of medical necessity and procedure report.
L8642	Hallux implant	Medical necessity review will be performed upon claims submission with supporting documentation	Investigative	Submit history and physical, documentation of medical necessity and procedure report.
L8681	Patient programmer (external) for use with implantable programmable neurostimulator pulse generator, replacement only	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, pre-op evaluation, operative report and documentation of medical necessity, including clerance from a licensed mental health professional
L8682	Implantable neurostimulator radiofrequency receiver	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, pre-op evaluation, operative report and documentation of medical necessity, including clerance from a licensed mental health professional
L8683	Radiofrequency transmitter (external) for use with implantable neurostimulator radiofrequency receiver	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, pre-op evaluation, operative report and documentation of medical necessity, including clerance from a licensed mental health professional
L8684	Radiofrequency transmitter (external) for use with implantable sacral root neurostimulator receiver for bowel and bladder management, replacement	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, pre-op evaluation, and operative report

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
L8685	Implantable neurostimulator pulse generator, single array, rechargeable, includes extension	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, pre-op evaluation, operative report and documentation of medical necessity, including clerance from a licensed mental health professional
L8686	Implantable neurostimulator pulse generator, single array, nonrechargeable, includes extension	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, pre-op evaluation, operative report and documentation of medical necessity, including clerance from a licensed mental health professional
L8687	Implantable neurostimulator pulse generator, dual array, rechargeable, includes extension	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, pre-op evaluation, operative report and documentation of medical necessity, including clerance from a licensed mental health professional
L8688	Implantable neurostimulator pulse generator, dual array, nonrechargeable, includes extension	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, pre-op evaluation, operative report and documentation of medical necessity, including clerance from a licensed mental health professional
L8689	External recharging system for battery (internal) for use with implantable neurostimulator, replacement only	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, pre-op evaluation, and operative report
L8699	Prosthetic implant, not otherwise specified	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	Submit the description of the item provided, cost invoice and letter of medical necessity from the ordering provider; no invoice needed if pricing not required.

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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	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition. medical necessity review will be performed upon claims submission with supporting documentation
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	Prior Authorization Required	Medical Necessity	History and physical, letter of/documentation of medical necessity, and functional status including evaluation from physiatrist and/or physical/occupational therapist (if applicable), and description of medical condition. medical necessity review will be performed upon claims submission with supporting documentation
L9900	Orthotic and prosthetic supply, accessory, and/or service component of another HCPCS L code	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	Submit letter of medical necessity, including description of the item, and manufacturer cost invoice
M0075	Cellular therapy	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
M0076	Prolotherapy	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
M0100	Intragastric hypothermia using gastric freezing	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
M0300	IV chelation therapy (chemical endarterectomy)	Medical necessity review will be performed upon claims submission with supporting documentation	Investigative	History and physical, including toxic exposures
P9020	Platelet rich plasma, each unit	Medical necessity review will be performed upon claims submission with supporting documentation	Investigative	History and physical and documentation related to condition being treated

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P9099	Blood component or product not otherwise classified	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	Submit documentation to describe the specific product being used
P9603	Travel allowance, one way in connection with medically necessary laboratory specimen collection drawn from homebound or nursing homebound patient; prorated miles actually travelled	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
P9604	Travel allowance, one way in connection with medically necessary laboratory specimen collection drawn from homebound or nursing homebound patient; prorated trip charge	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
Q0138	Injection, ferumoxytol, for treatment of iron deficiency anemia, 1 mg (non-ESRD use)	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and Physical, clinical notes related to a condition being treated, documentation of previous therapies tried and failed.
Q0139	Injection, ferumoxytol, for treatment of iron deficiency anemia, 1 mg (for ESRD on dialysis)	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and Physical, clinical notes related to a condition being treated, documentation of previous therapies tried and failed.
Q0181	Unspecified oral dosage form, FDA-approved prescription antiemetic, for use as a complete therapeutic substitute for an IV antiemetic at the time of chemotherapy treatment, not to exceed a 48-hour dosage regimen	Prior Authorization Required	Medical Necessity	History and physical, clinical notes related to a condition being treated, documentation of medical necessity, including name of drug and NDC number and quantity
Q0515	Injection, sermorelin acetate, 1 mcg	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
Q1004	NEW TECH IO LENS CATGY 4 FED REG	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
Q1005	NEW TECH IO LENS CATGY 5 FED REG	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.

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Q2026	Injection, Radiesse, 0.1ML	Medical necessity review will be performed upon claims submission with supporting documentation	Potential Contract Exclusion	Documentation from provider related to member's condition and treatment
Q2028	Injection, sculptra, 0.5 mg	Medical necessity review will be performed upon claims submission with supporting documentation	Potential Contract Exclusion	Documentation from provider related to member's condition and treatment
Q2040	Tisagenlecleucel, up to 250 million CAR-positive viable T cells, including leukapheresis and dose preparation procedures, per infusion	Prior Authorization Required	Medical Necessity	History and Physical, documentation of medical necessity
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	History and physical, documentation of medical necessity, and treatment plan. Note: Claims for this drug are processed through the local plan, not pharmacy
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	History and physical, documentation of medical necessity, and treatment plan
Q2043	Sipuleucel-t, minimum of 50 million autologous cd54+ cells activated with pap-gm-csf, including leukapheresis and all other preparatory procedures, per infusion	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and physical, clinical notes related to a condition being treated, treatment plan. NOTE: Claims for this drug are processed through the Local Plan, not pharmacy. medical necessity review will be performed upon claims submission with supporting documentation
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	History and physical, documentation of medical necessity, and treatment plan

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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	History and physical, documentation of medical necessity, and treatment plan
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	History and physical, documentation of medical necessity, and treatment plan
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	History and physical, documentation of medical necessity, and treatment plan
Q2057	Afamitresgene autoleucel, including leukapheresis and dose preparation procedures, per therapeutic dose	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity and previously tried therapies
Q2058	Obecabtagene autoleucel, 10 up to 400 million CD19 CAR-positive viable T cells, including leukapheresis and dose preparation procedures, per infusion	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
Q3014	Telehealth originating site facility fee	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
Q3027	Injection, interferon beta-1a, 1 mcg for intramuscular use	Advance Benefit Determination (ABD) recommended	Medical Necessity	Benefits for this drug are limited to once per lifetime when provided by a physician, health care professional or hospital. Please direct providers and members to the Specialty Pharmacy Program at 888-346-3731 or visit the Pharmacy section on www.fepblue.org

To search: Use CTRL+F for PCs or Command+F for Macs, and type in the code.
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Code List

Code	Description	Plan Review Requirement	Reviewed For	Records Request
Q3028	Injection, interferon beta-1a, 1 mcg for subcutaneous use	Advance Benefit Determination (ABD) recommended	Medical Necessity	Benefits for this drug are limited to once per lifetime when provided by a physician, health care professional or hospital. Please direct providers and members to the Specialty Pharmacy Program at 888-346-3731 or visit the Pharmacy section on www.fepblue.org
Q3031	Collogen skin test	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
Q4074	Iloprost, inhalation solution, FDA-approved final product, noncompounded, administered through DME, unit dose form, up to 20 mcg	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and Physical, Office notes related to a condition being treated
Q4081	Injection, epoetin alfa, 100 units (for ESRD on dialysis)	Advance Benefit Determination (ABD) recommended	Medical Necessity	Submit history and physical from ordering physician, with Hgb level and transferrin saturation or ferritin level within 1 month of starting treatment, documentation of previous erythropoietin stimulating agent tried and failed.
Q4082	Drug or biological, not otherwise classified, Part B drug competitive acquisition program (CAP)	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
Q4100	Skin substitute, not otherwise specified	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
Q4101	Apligraf, per sq cm	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
Q4102	Oasis wound matrix, per sq cm	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, documentation of medical necessity, and procedure report

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Code List

Code	Description	Plan Review Requirement	Reviewed For	Records Request
Q4103	Oasis burn matrix, per square centimeter (add-on, list separately in addition to primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
Q4104	Integra bilayer matrix wound dressing (BMWD), per square centimeter (add-on, list separately in addition to primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
Q4105	Integra dermal regeneration template (DRT) or Integra Omnigraft dermal regeneration matrix, per sq cm	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
Q4106	Dermagraft, per sq cm	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
Q4107	GRAFTJACKET, per square centimeter (add-on, list separately in addition to primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Investigative	History and physical, documentation of medical necessity, and procedure report
Q4108	Integra matrix, per square centimeter (add-on, list separately in addition to primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
Q4110	PriMatrix, per square centimeter (add-on, list separately in addition to primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
Q4111	GammaGraft, per square centimeter (add-on, list separately in addition to primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Investigative	History and physical, documentation of medical necessity, and procedure report
Q4112	Cymetra, injectable, 1 cc	Medical necessity review will be performed upon claims submission with supporting documentation	Investigative	History and physical, documentation of medical necessity, and procedure report

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Code List

Code	Description	Plan Review Requirement	Reviewed For	Records Request
Q4113	GRAFTJACKET XPRESS, injectable, 1cc	Medical necessity review will be performed upon claims submission with supporting documentation	Investigative	History and physical, documentation of medical necessity, and procedure report
Q4114	Integra flowable wound matrix, injectable, 1 cc	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
Q4115	AlloSkin, per square centimeter (add-on, list separately in addition to primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Investigative	History and physical, documentation of medical necessity, and procedure report
Q4116	AlloDerm, per sq cm	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
Q4117	HYALOMATRIX, per square centimeter (add-on, list separately in addition to primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
Q4118	MatriStem micromatrix, 1 mg	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
Q4121	TheraSkin, per square centimeter (add-on, list separately in addition to primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Investigative	History and physical, documentation of medical necessity, and procedure report
Q4122	DermACELL, DermACELL AWM or DermACELL AWM Porous, per sq cm	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
Q4123	AlloSkin RT, per square centimeter (add-on, list separately in addition to primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Investigative	History and physical, documentation of medical necessity, and procedure report

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Code List

Code	Description	Plan Review Requirement	Reviewed For	Records Request
Q4124	OASIS ultra tri-layer wound matrix, per square centimeter (add-on, list separately in addition to primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
Q4125	Arthroflex, per square centimeter (add-on, list separately in addition to primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Investigative	History and physical, documentation of medical necessity, and procedure report
Q4126	MemoDerm, DermaSpan, TranZgraft or InteguPly, per square centimeter (add-on, list separately in addition to primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Investigative	History and physical, documentation of medical necessity, and procedure report
Q4127	Talymed, per square centimeter (add-on, list separately in addition to primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
Q4128	FlexHD or AllopatchHD, per sq cm	Medical necessity review will be performed upon claims submission with supporting documentation	Investigative	History and physical, documentation of medical necessity, and procedure report
Q4130	Strattice TM, per square centimeter (add-on, list separately in addition to primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
Q4132	Grafix Core and GrafixPL Core, per square centimeter (add-on, list separately in addition to primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
Q4133	Grafix PRIME, GrafixPL PRIME, Stravix and StravixPL, per square centimeter (add-on, list separately in addition to primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
Q4134	HMatrix, per square centimeter (add-on, list separately in addition to primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Investigative	History and physical, documentation of medical necessity, and procedure report

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Code List

Code	Description	Plan Review Requirement	Reviewed For	Records Request
Q4135	Mediskin, per square centimeter (add-on, list separately in addition to primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
Q4136	E-Z Derm, per square centimeter (add-on, list separately in addition to primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
Q4137	AmnioExcel, AmnioExcel Plus or Biodexcel, per square centimeter (add-on, list separately in addition to primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Investigative	History and physical, documentation of medical necessity, and procedure report
Q4138	BioDFence DryFlex, per square centimeter (add-on, list separately in addition to primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Investigative	History and physical, documentation of medical necessity, and procedure report
Q4139	Amniomatrix or biodmatrix, injectable, 1 cc	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
Q4140	BioDFence, per square centimeter (add-on, list separately in addition to primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
Q4141	AlloSkin AC, per square centimeter (add-on, list separately in addition to primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
Q4142	XCM biologic tissue matrix, per square centimeter (add-on, list separately in addition to primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
Q4143	Repriza, per square centimeter (add-on, list separately in addition to primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Investigative	History and physical, documentation of medical necessity, and procedure report

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Code List

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Q4145	EpiFix, injectable, 1 mg	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
Q4146	Tensix, per square centimeter (add-on, list separately in addition to primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
Q4147	Architect, Architect PX, or Architect FX, extracellular matrix, per square centimeter (add-on, list separately in addition to primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
Q4148	Neox Cord 1k, Neox Cord-RT, or Clarix Cord 1K, per square centimeter (add-on, list separately in addition to primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Investigative	History and physical, documentation of medical necessity, and procedure report
Q4149	Excellagen, 0.1 cc	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
Q4150	AlloWrap DS or dry, per square centimeter (add-on, list separately in addition to primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Investigative	History and physical, documentation of medical necessity, and procedure report
Q4151	AmnioBand or Guardian, per square centimeter (add-on, list separately in addition to primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
Q4152	DermaPure, per square centimeter (add-on, list separately in addition to primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
Q4153	Dermavest and Plurivest, per square centimeter (add-on, list separately in addition to primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Investigative	History and physical, documentation of medical necessity, and procedure report

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Code List

Code	Description	Plan Review Requirement	Reviewed For	Records Request
Q4154	Biovance, per square centimeter (add-on, list separately in addition to primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
Q4155	Neox Flo or Clarix Flo 1 mg	Medical necessity review will be performed upon claims submission with supporting documentation	Investigative	History and physical, documentation of medical necessity, and procedure report
Q4156	Neox 100 or Clarix 100, per sq cm (e.g., NeoxWound) (add-on, list separately in addition to primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
Q4157	Revitalon, per square centimeter (add-on, list separately in addition to primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Investigative	History and physical, documentation of medical necessity, and procedure report
Q4158	Kerecis Omega3, per square centimeter (add-on, list separately in addition to primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
Q4159	Affinity, per square centimeter (add-on, list separately in addition to primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Investigative	History and physical, documentation of medical necessity, and procedure report
Q4160	Nushield, per square centimeter (add-on, list separately in addition to primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Investigative	History and physical, documentation of medical necessity, and procedure report
Q4161	Bio-ConneKt wound matrix, per square centimeter (add-on, list separately in addition to primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
Q4162	AmnioPro Flow, BioSkin Flow, BioRenew Flow, WoundEx Flow, Amniogen-A, Amniogen-C, 0.5 cc	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, documentation of medical necessity, and procedure report

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Code List

Code	Description	Plan Review Requirement	Reviewed For	Records Request
Q4163	WoundEx,, BioSkin,, per square centimeter (add-on, list separately in addition to primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
Q4164	Helicoll, per square centimeter (add-on, list separately in addition to primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
Q4165	Keramatrix or Kerasorb, per square centimeter (add-on, list separately in addition to primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
Q4166	Cytal, per square centimeter (add-on, list separately in addition to primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Investigative	History and physical, documentation of medical necessity, and procedure report
Q4167	Truskin, per square centimeter (add-on, list separately in addition to primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
Q4168	AmnioBand, 1 mg	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
Q4169	Artacent Wound, per square centimeter (add-on, list separately in addition to primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
Q4170	Cygnus per square centimeter (add-on, list separately in addition to primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
Q4171	Interfyl, 1 mg	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, documentation of medical necessity, and procedure report

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
Q4173	PalinGen or PalinGen XPlus, per square centimeter (add-on, list separately in addition to primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
Q4174	PalinGen or ProMatrX, 0.36 mg per 0.25 cc	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
Q4175	Miroderm, per square centimeter (add-on, list separately in addition to primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
Q4176	Neopatch or Therion, per square centimeter (add-on, list separately in addition to primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Investigative	History and physical, documentation of medical necessity, and procedure report
Q4177	FlowerAmnioFlo, 0.1 cc	Medical necessity review will be performed upon claims submission with supporting documentation	Investigative	History and physical, documentation of medical necessity, and procedure report
Q4178	FlowerAmnioPatch, per square centimeter (add-on, list separately in addition to primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Investigative	History and physical, documentation of medical necessity, and procedure report
Q4179	FlowerDerm, per square centimeter (add-on, list separately in addition to primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Investigative	History and physical, documentation of medical necessity, and procedure report
Q4180	Revita, per square centimeter (add-on, list separately in addition to primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Investigative	History and physical, documentation of medical necessity, and procedure report
Q4181	Amnio Wound, per square centimeter (add-on, list separately in addition to primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Investigative	History and physical, documentation of medical necessity, and procedure report

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
Q4182	Transcyte, per square centimeter (add-on, list separately in addition to primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
Q4183	SurgiGRAFT, per square centimeter (add-on, list separately in addition to primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Investigative	History and physical, documentation of medical necessity, and procedure report
Q4184	Cellesta or Cellesta Duo, per square centimeter (add-on, list separately in addition to primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Investigative	History and physical, documentation of medical necessity, and procedure report
Q4185	Cellesta flowable amnion (25 mg per cc); per 0.5 cc	Medical necessity review will be performed upon claims submission with supporting documentation	Investigative	History and physical, documentation of medical necessity, and procedure report
Q4186	Epifix, per square centimeter (add-on, list separately in addition to primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
Q4187	EpiCord, per square centimeter (add-on, list separately in addition to primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Investigative	History and physical, documentation of medical necessity, and procedure report
Q4188	AmnioArmor, per square centimeter (add-on, list separately in addition to primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Investigative	History and physical, documentation of medical necessity, and procedure report
Q4189	Artacent ac, 1 mg	Medical necessity review will be performed upon claims submission with supporting documentation	Investigative	History and physical, documentation of medical necessity, and procedure report
Q4190	Artacent AC, per square centimeter (add-on, list separately in addition to primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Investigative	History and physical, documentation of medical necessity, and procedure report

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
Q4191	Restorigin, per square centimeter (add-on, list separately in addition to primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Investigative	History and physical, documentation of medical necessity, and procedure report
Q4192	Restorigin, 1 cc	Medical necessity review will be performed upon claims submission with supporting documentation	Investigative	History and physical, documentation of medical necessity, and procedure report
Q4193	Coll-e-derm, per square centimeter (add-on, list separately in addition to primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Investigative	History and physical, documentation of medical necessity, and procedure report
Q4194	Novachor, per square centimeter (add-on, list separately in addition to primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Investigative	History and physical, documentation of medical necessity, and procedure report
Q4195	Puraply, per square centimeter (add-on, list separately in addition to primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Investigative	History and physical, documentation of medical necessity, and procedure report
Q4196	Puraply am, per square centimeter (add-on, list separately in addition to primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Investigative	History and physical, documentation of medical necessity, and procedure report
Q4197	Puraply xt, per square centimeter (add-on, list separately in addition to primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Investigative	History and physical, documentation of medical necessity, and procedure report
Q4198	Genesis Amniotic Membrane, per square centimeter (add-on, list separately in addition to primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Investigative	History and physical, documentation of medical necessity, and procedure report
Q4199	Cygnus Matrix, per square centimeter (add-on, list separately in addition to primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, documentation of medical necessity, and procedure report

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
Q4200	SkinTE, per square centimeter (add-on, list separately in addition to primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Investigative	History and physical, documentation of medical necessity, and procedure report
Q4201	Matrion, per square centimeter (add-on, list separately in addition to primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Investigative	History and physical, documentation of medical necessity, and procedure report
Q4202	Keroxx (2.5g/cc), 1cc	Medical necessity review will be performed upon claims submission with supporting documentation	Investigative	History and physical, documentation of medical necessity, and procedure report
Q4203	Derma-Gide, per square centimeter (add-on, list separately in addition to primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Investigative	History and physical, documentation of medical necessity, and procedure report
Q4204	XWRAP, per square centimeter (add-on, list separately in addition to primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Investigative	History and physical, documentation of medical necessity, and procedure report
Q4205	Membrane Graft or Membrane Wrap, per square centimeter (add-on, list separately in addition to primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
Q4206	Fluid Flow or Fluid GF, 1 cc	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
Q4208	Novafix, per square centimeter (add-on, list separately in addition to primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
Q4209	SurGraft, per square centimeter (add-on, list separately in addition to primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, documentation of medical necessity, and procedure report

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Q4211	Amnion Bio or AxoBioMembrane, per square centimeter (add-on, list separately in addition to primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
Q4212	AlloGen, per cc	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
Q4213	Ascent, 0.5 mg	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
Q4214	Cellesta Cord, per square centimeter (add-on, list separately in addition to primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
Q4215	Axolotl Ambient or Axolotl Cryo, 0.1 mg	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
Q4216	Artacent Cord, per square centimeter (add-on, list separately in addition to primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
Q4217	WoundFix, BioWound, WoundFix Plus, BioWound Plus, WoundFix Xplus or BioWound Xplus, per square centimeter (add-on, list separately in addition to primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
Q4218	SurgiCORD, per square centimeter (add-on, list separately in addition to primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
Q4219	SurgiGRAFT-DUAL, per sq cm	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, documentation of medical necessity, and procedure report

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Code List

Code	Description	Plan Review Requirement	Reviewed For	Records Request
Q4220	BellaCell HD or Surederm, per square centimeter (add-on, list separately in addition to primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
Q4221	Amnio Wrap2, per square centimeter (add-on, list separately in addition to primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
Q4222	ProgenaMatrix, per square centimeter (add-on, list separately in addition to primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
Q4224	Human Health Factor 10 amniotic patch (hhf10-p), per square centimeter (add-on, list separately in addition to primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
Q4225	AmnioBind, per square centimeter (add-on, list separately in addition to primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
Q4226	MyOwn Skin, includes harvesting and preparation procedures, per sq cm	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
Q4227	AmnioCore per square centimeter (add-on, list separately in addition to primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
Q4229	Cogenex Amniotic Membrane, per square centimeter (add-on, list separately in addition to primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
Q4230	Cogenex Flowable Amnion, per 0.5 cc	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, documentation of medical necessity, and procedure report

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Code List

Code	Description	Plan Review Requirement	Reviewed For	Records Request
Q4232	Corplex, per square centimeter (add-on, list separately in addition to primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
Q4233	SurFactor or NuDyn, per 0.5 cc	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
Q4234	XCellerate, per square centimeter (add-on, list separately in addition to primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
Q4235	Amniorepair or AltiPly, per square centimeter (add-on, list separately in addition to primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
Q4236	CarePATCH, per square centimeter (add-on, list separately in addition to primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
Q4237	Cryo-Cord, per square centimeter (add-on, list separately in addition to primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
Q4238	Derm-Maxx, per square centimeter (add-on, list separately in addition to primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
Q4239	Amnio-maxx or Amnio-maxx Lite, per square centimeter (add-on, list separately in addition to primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
Q4240	CoreCyte, for topical use only, per 0.5 cc	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, documentation of medical necessity, and procedure report

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Code List

Code	Description	Plan Review Requirement	Reviewed For	Records Request
Q4241	PolyCyte, for topical use only, per 0.5 cc	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
Q4242	AmnioCyte Plus, per 0.5 cc	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
Q4245	AmnioText, per cc	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
Q4246	CoreText or ProText, per cc	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
Q4247	Amniotext patch, per square centimeter (add-on, list separately in addition to primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
Q4248	Dermacyte Amniotic Membrane Allograft, per square centimeter (add-on, list separately in addition to primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
Q4249	Amniply, for topical use only, per square centimeter (add-on, list separately in addition to primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Investigative	History and physical, documentation of medical necessity, and procedure report
Q4250	AmnioAmp-MPMP, per square centimeter (add-on, list separately in addition to primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Investigative	History and physical, documentation of medical necessity, and procedure report
Q4251	Vim, per sq cm	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, documentation of medical necessity, and procedure report

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Code List

Code	Description	Plan Review Requirement	Reviewed For	Records Request
Q4252	Vendaje, per square centimeter (add-on, list separately in addition to primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
Q4253	Zenith Amniotic Membrane, per square centimeter (add-on, list separately in addition to primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
Q4254	Novafix DL, per square centimeter (add-on, list separately in addition to primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Investigative	History and physical, documentation of medical necessity, and procedure report
Q4255	REGUaRD, for topical use only, per square centimeter (add-on, list separately in addition to primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Investigative	History and physical, documentation of medical necessity, and procedure report
Q4256	MLG-CompleteTM, per square centimeter (add-on, list separately in addition to primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
Q4257	Release, per square centimeter (add-on, list separately in addition to primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
Q4258	Enverse, per square centimeter (add-on, list separately in addition to primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
Q4259	Celera Dual Layer or Celera Dual Membrane, per square centimeter (add-on, list separately in addition to primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
Q4260	Signature APatch, per square centimeter (add-on, list separately in addition to primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, documentation of medical necessity, and procedure report

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Code List

Code	Description	Plan Review Requirement	Reviewed For	Records Request
Q4261	TAG, per square centimeter (add-on, list separately in addition to primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
Q4262	Dual Layer Impax Membrane, per square centimeter (add-on, list separately in addition to primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
Q4263	SurGraft TL, per square centimeter (add-on, list separately in addition to primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
Q4264	Cocoon Membrane, per square centimeter (add-on, list separately in addition to primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
Q4265	Neostim TL, per square centimeter (add-on, list separately in addition to primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Investigative	History and physical, documentation of medical necessity, and procedure report
Q4266	Neostim membrane, per square centimeter (add-on, list separately in addition to primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Investigative	History and physical, documentation of medical necessity, and procedure report
Q4267	Neostim DL, per square centimeter (add-on, list separately in addition to primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Investigative	History and physical, documentation of medical necessity, and procedure report
Q4268	SurGraft FT, per square centimeter (add-on, list separately in addition to primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Investigative	History and physical, documentation of medical necessity, and procedure report
Q4269	SurGraft XT, per square centimeter (add-on, list separately in addition to primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Investigative	History and physical, documentation of medical necessity, and procedure report

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Code List

Code	Description	Plan Review Requirement	Reviewed For	Records Request
Q4270	Complete SL, per square centimeter (add-on, list separately in addition to primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Investigative	History and physical, documentation of medical necessity, and procedure report
Q4271	Complete FT, per square centimeter (add-on, list separately in addition to primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Investigative	History and physical, documentation of medical necessity, and procedure report
Q4272	Esano a, per square centimeter (add-on, list separately in addition to primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
Q4273	Esano aaa, per square centimeter (add-on, list separately in addition to primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
Q4274	Esano ac, per square centimeter (add-on, list separately in addition to primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
Q4275	Esano aca, per square centimeter (add-on, list separately in addition to primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
Q4276	Orion, per square centimeter (add-on, list separately in addition to primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
Q4278	Epieffect, per square centimeter (add-on, list separately in addition to primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
Q4279	Vendaje AC, per square centimeter (add-on, list separately in addition to primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, documentation of medical necessity, and procedure report

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Code List

Code	Description	Plan Review Requirement	Reviewed For	Records Request
Q4280	Xcell amnio matrix, per square centimeter (add-on, list separately in addition to primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
Q4281	Barrera SL or Barrera DL, per square centimeter (add-on, list separately in addition to primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
Q4282	Cygnus dual, per square centimeter (add-on, list separately in addition to primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
Q4283	Biovance tri-layer or Biovance 3l, per square centimeter (add-on, list separately in addition to primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
Q4284	Dermabind SL, per square centimeter (add-on, list separately in addition to primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
Q4285	Nudyn DL or Nudyn DL Mesh, per square centimeter (add-on, list separately in addition to primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
Q4286	Nudyn SL or Nudyn SLW, per square centimeter (add-on, list separately in addition to primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
Q4287	DermaBind DL, per square centimeter (add-on, list separately in addition to primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
Q4288	DermaBind CH, per square centimeter (add-on, list separately in addition to primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, documentation of medical necessity, and procedure report

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Code List

Code	Description	Plan Review Requirement	Reviewed For	Records Request
Q4289	RevoShield+ Amniotic Barrier, per square centimeter (add-on, list separately in addition to primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
Q4290	Membrane Wrap-Hydro, per square centimeter (add-on, list separately in addition to primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
Q4291	Lamellas XT, per square centimeter (add-on, list separately in addition to primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
Q4292	Lamellas, per square centimeter (add-on, list separately in addition to primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
Q4293	Acesso DL, per square centimeter (add-on, list separately in addition to primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
Q4294	Amnio Quad-Core, per square centimeter (add-on, list separately in addition to primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
Q4295	Amnio Tri-Core Amniotic, per square centimeter (add-on, list separately in addition to primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
Q4296	Rebound Matrix, per square centimeter (add-on, list separately in addition to primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
Q4297	Emerge Matrix, per square centimeter (add-on, list separately in addition to primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, documentation of medical necessity, and procedure report

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Code List

Code	Description	Plan Review Requirement	Reviewed For	Records Request
Q4298	AmniCore Pro, per square centimeter (add-on, list separately in addition to primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
Q4299	AmniCore Pro+, per square centimeter (add-on, list separately in addition to primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
Q4300	Acesso TL, per square centimeter (add-on, list separately in addition to primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
Q4301	Activate Matrix, per square centimeter (add-on, list separately in addition to primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
Q4302	Complete ACA, per square centimeter (add-on, list separately in addition to primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
Q4303	Complete AA, per square centimeter (add-on, list separately in addition to primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
Q4304	GRAFIX PLUS, per square centimeter (add-on, list separately in addition to primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
Q4305	American amnion ac tri-layer, per square centimeter (add-on, list separately in addition to primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
Q4306	American amnion ac, per square centimeter (add-on, list separately in addition to primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, documentation of medical necessity, and procedure report

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Code List

Code	Description	Plan Review Requirement	Reviewed For	Records Request
Q4307	American amnion, per square centimeter (add-on, list separately in addition to primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
Q4308	Sanopellis, per square centimeter (add-on, list separately in addition to primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
Q4309	Via matrix, per square centimeter (add-on, list separately in addition to primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
Q4310	Procenta, per 100 mg	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
Q4311	Acesso, per square centimeter (add-on, list separately in addition to primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
Q4312	Acesso AC, per square centimeter (add-on, list separately in addition to primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
Q4313	Dermabind FM, per square centimeter (add-on, list separately in addition to primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
Q4314	Reeva FT, per square centimeter (add-on, list separately in addition to primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
Q4315	Regenelink amniotic membrane allograft per square centimeter (add-on, list separately in addition to primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, documentation of medical necessity, and procedure report

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Code List

Code	Description	Plan Review Requirement	Reviewed For	Records Request
Q4316	Amchoplast, per square centimeter (add-on, list separately in addition to primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
Q4317	Vitograft, per square centimeter (add-on, list separately in addition to primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
Q4318	E-graft, per square centimeter	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
Q4319	Sanograft, per square centimeter (add-on, list separately in addition to primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
Q4320	Pellograft, per square centimeter (add-on, list separately in addition to primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
Q4321	Renograft, per square centimeter (add-on, list separately in addition to primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
Q4322	Caregraft, per square centimeter (add-on, list separately in addition to primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
Q4323	Alloply, per square centimeter (add-on, list separately in addition to primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
Q4324	Amniotx, per square centimeter (add-on, list separately in addition to primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, documentation of medical necessity, and procedure report

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Code List

Code	Description	Plan Review Requirement	Reviewed For	Records Request
Q4325	Acapatch, per square centimeter (add-on, list separately in addition to primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
Q4326	Woundplus, per square centimeter (add-on, list separately in addition to primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
Q4327	Duoamnion, per square centimeter (add-on, list separately in addition to primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
Q4328	Most, per square centimeter (add-on, list separately in addition to primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
Q4329	Singlay, per square centimeter (add-on, list separately in addition to primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
Q4330	Total, per square centimeter (add-on, list separately in addition to primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
Q4331	Axolotl graft, per square centimeter (add-on, list separately in addition to primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
Q4332	Axolotl dualgraft, per square centimeter (add-on, list separately in addition to primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
Q4333	Ardeograft, per square centimeter (add-on, list separately in addition to primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, documentation of medical necessity, and procedure report

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Code List

Code	Description	Plan Review Requirement	Reviewed For	Records Request
Q4345	Matrix hd allograft dermis, per square centimeter (add-on, list separately in addition to primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
Q4346	Shelter DM matrix, per square centimeter (add-on, list separately in addition to primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
Q4347	Rampart DL matrix, per square centimeter (add-on, list separately in addition to primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
Q4348	Sentry SL matrix, per square centimeter (add-on, list separately in addition to primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
Q4349	Mantle DL matrix, per square centimeter (add-on, list separately in addition to primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
Q4350	Palisade DM matrix, per square centimeter (add-on, list separately in addition to primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
Q4351	Enclose TL matrix, per square centimeter (add-on, list separately in addition to primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
Q4352	Overlay SL matrix, per square centimeter (add-on, list separately in addition to primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
Q4353	Xceed TL matrix, per square centimeter (add-on, list separately in addition to primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, documentation of medical necessity, and procedure report

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Code List

Code	Description	Plan Review Requirement	Reviewed For	Records Request
Q4354	Palingen Dual-layer membrane, per square centimeter (add-on, list separately in addition to primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Investigative	History and physical, documentation of medical necessity, and procedure report
Q4355	Abiomend Xplus membrane and Abiomend Xplus hydromembrane, per square centimeter (add-on, list separately in addition to primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Investigative	History and physical, documentation of medical necessity, and procedure report
Q4356	Abiomend membrane and abiomend hydromembrane, per square centimeter	Medical necessity review will be performed upon claims submission with supporting documentation	Investigative	History and physical, documentation of medical necessity, and procedure report
Q4357	Xwrap Plus, per square centimeter (add-on, list separately in addition to primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Investigative	History and physical, documentation of medical necessity, and procedure report
Q4358	Xwrap Dual, per square centimeter (add-on, list separately in addition to primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Investigative	History and physical, documentation of medical necessity, and procedure report
Q4359	Choriply, per square centimeter (add-on, list separately in addition to primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Investigative	History and physical, documentation of medical necessity, and procedure report
Q4360	Amchoplast FD, per square centimeter (add-on, list separately in addition to primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Investigative	History and physical, documentation of medical necessity, and procedure report
Q4361	Epixpress, per square centimeter (add-on, list separately in addition to primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Investigative	History and physical, documentation of medical necessity, and procedure report
Q4362	Cygnus Disk, per square centimeter (add-on, list separately in addition to primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Investigative	History and physical, documentation of medical necessity, and procedure report

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Code List

Code	Description	Plan Review Requirement	Reviewed For	Records Request
Q4363	Amnio Burgeon Membrane and Hydromembrane, per square centimeter (add-on, list separately in addition to primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Investigative	History and physical, documentation of medical necessity, and procedure report
Q4364	Amnio Burgeon Xplus Membrane and Xplus Hydromembrane, per square centimeter (add-on, list separately in addition to primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Investigative	History and physical, documentation of medical necessity, and procedure report
Q4365	Amnio Burgeon Dual-layer Membrane, per square centimeter (add-on, list separately in addition to primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Investigative	History and physical, documentation of medical necessity, and procedure report
Q4366	Amnio Burgeon X-membrane dual layer, per square centimeter (add-on, list separately in addition to primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Investigative	History and physical, documentation of medical necessity, and procedure report
Q4367	Amniocore SL, per square centimeter (add-on, list separately in addition to primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Investigative	History and physical, documentation of medical necessity, and procedure report
Q4368	AmchoThick, per square centimeter (add-on, list separately in addition to primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
Q4369	AmnioPlast 3, per square centimeter (add-on, list separately in addition to primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
Q4370	AeroGuard, per square centimeter (add-on, list separately in addition to primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
Q4371	NeoGuard, per square centimeter (add-on, list separately in addition to primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, documentation of medical necessity, and procedure report

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Code List

Code	Description	Plan Review Requirement	Reviewed For	Records Request
Q4372	AmchoPlast EXCEL, per square centimeter (add-on, list separately in addition to primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
Q4373	Membrane Wrap-Lite, per square centimeter (add-on, list separately in addition to primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
Q4375	Duograft AC, per square centimeter (add-on, list separately in addition to primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
Q4376	Duograft AA, per square centimeter (add-on, list separately in addition to primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
Q4377	triGRAFT FT, per square centimeter (add-on, list separately in addition to primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
Q4378	Renew FT Matrix, per square centimeter (add-on, list separately in addition to primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
Q4379	AmnioDefend FT Matrix, per square centimeter (add-on, list separately in addition to primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
Q4380	AdvoGraft One, per square centimeter (add-on, list separately in addition to primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
Q4382	AdvoGraft Dual, per square centimeter (add-on, list separately in addition to primary procedure)	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, documentation of medical necessity, and procedure report

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Code List

Code	Description	Plan Review Requirement	Reviewed For	Records Request
Q5005	Hospice care provided in inpatient hospital	Prior Authorization Required	Potential Contract Exclusion	Submit hospice treatment plan, including physician certification of terminal illness
Q5006	Hospice care provided in inpatient hospice facility	Prior Authorization Required	Potential Contract Exclusion	Submit hospice treatment plan, including physician certification of terminal illness
Q5008	Hospice care provided in inpatient psychiatric facility	Prior Authorization Required	Potential Contract Exclusion	Submit hospice treatment plan, including physician certification of terminal illness
Q5009	Hospice or home health care provided in place not otherwise specified (nos)	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
Q5010	Hospice home care provided in a hospice facility	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
Q5098	Injection, ustekinumab-srlf (Imuldosa), biosimilar, 1 mg	Prior Authorization Required	Medical Necessity	History and Physical, clinical notes related to a condition being treated, documentation of previous therapies tried and failed.
Q5099	Injection, ustekinumab-stba (Steqeyma), biosimilar, 1 mg	Prior Authorization Required	Medical Necessity	History and Physical, clinical notes related to a condition being treated, documentation of previous therapies tried and failed.
Q5100	Injection, ustekinumab-kfce (Yesintek), biosimilar, 1 mg	Prior Authorization Required	Medical Necessity	History and Physical, clinical notes related to a condition being treated, documentation of previous therapies tried and failed.
Q5101	Injection, filgrastim-sndz, biosimilar, (zarxio), 1 microgram	Prior Authorization Required	Medical Necessity	History and physical, and clinical notes of condition being treated, including documentation of previous therapies tried and failed, and proposed treatment plan
Q5103	Injection, infliximab-dyyb, biosimilar, (inflectra), 10 mg	Prior Authorization Required	Medical Necessity	History and physical, and clinical notes of condition being treated, including documentation of previous therapies tried and failed, and proposed treatment plan

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
Q5104	Injection, infliximab-abda, biosimilar, (renflexis), 10 mg	Prior Authorization Required	Medical Necessity	History and physical, and clinical notes of condition being treated, including documentation of previous therapies tried and failed, and proposed treatment plan
Q5105	Injection, Epoetin Alfa-EPBX, Biosimilar, (Retacrit) (for ESRD on dialysis), 100 units	Prior Authorization Required	Medical Necessity	Submit history and physical from ordering physician, with Hgb level and transferrin saturation or ferritin level within 1 month of starting treatment, documentation of previous erythropoietin stimulating agent tried and failed.
Q5106	Injection, Epoetin Alfa-EPBX, Biosimilar, (Retacrit) (for non-ESRD use), 1000 units	Prior Authorization Required	Medical Necessity	History and physical with hemoglobin level and transferrin saturation or ferritin level within one month of starting treatment, and documentation of previous erythropoietin stimulating agent(s) tried and failed, and proposed treatment plan
Q5107	Injection, bevacizumab-awwb, biosimilar, (mvasi), 10 mg	Prior Authorization Required	Medical Necessity	History and physical, and clinical notes of condition being treated, including documentation of previous therapies tried and failed, and proposed treatment plan
Q5108	Injection, pegfilgrastim-jmdb (fulphila), biosimilar,0.5 mg	Prior Authorization Required	Medical Necessity	History and physical, and clinical notes of condition being treated, including documentation of previous therapies tried and failed, and proposed treatment plan
Q5110	Injection, filgrastim-aafi, biosimilar, (nivestym), 1 microgram	Prior Authorization Required	Medical Necessity	History and physical, and clinical notes of condition being treated, including documentation of previous therapies tried and failed, and proposed treatment plan

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Q5111	Injection, pegfilgrastim-cbqv (Udenyca), biosimilar, 0.5 mg	Prior Authorization Required	Medical Necessity	History and physical, and clinical notes of condition being treated, including documentation of previous therapies tried and failed, and proposed treatment plan
Q5112	Injection, trastuzumab-dttb, biosimilar, (Ontruzant), 10 mg	Prior Authorization Required	Medical Necessity	History and physical, and clinical notes of condition being treated, including documentation of previous therapies tried and failed, and proposed treatment plan
Q5113	Injection, trastuzumab-pkrb, biosimilar, (Herzuma), 10 mg	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, including recent lab work and any other attempted medications and response(s), if applicable
Q5114	Injection, Trastuzumab-dkst, biosimilar, (Ogivri), 10 mg	Prior Authorization Required	Medical Necessity	History and physical, and clinical notes of condition being treated, including documentation of previous therapies tried and failed, and proposed treatment plan
Q5115	Injection, rituximab-abbs, biosimilar, (Truxima), 10 mg	Prior Authorization Required	Medical Necessity	History and physical, and clinical notes of condition being treated, including documentation of previous therapies tried and failed, and proposed treatment plan
Q5116	Injection, trastuzumab-qyyp, biosimilar, (Trazimera), 10 mg	Prior Authorization Required	Medical Necessity	History and physical, and clinical notes of condition being treated, including documentation of previous therapies tried and failed, and proposed treatment plan
Q5117	Injection, trastuzumab-anns, biosimilar, (Kanjinti), 10 mg	Prior Authorization Required	Medical Necessity	History and physical, and clinical notes of condition being treated, including documentation of previous therapies tried and failed, and proposed treatment plan

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Q5118	Injection, bevacizumab-bvcr, biosimilar, (Zirabev), 10 mg	Prior Authorization Required	Medical Necessity	History and physical, and clinical notes of condition being treated, including documentation of previous therapies tried and failed, and proposed treatment plan
Q5119	Injection, rituximab-pvvr, biosimilar, (RUXIENCE), 10 mg	Prior Authorization Required	Medical Necessity	History and physical, and clinical notes of condition being treated, including documentation of previous therapies tried and failed, and proposed treatment plan
Q5120	Injection, pegfilgrastim-bmez (ZIEXTENZO), biosimilar, 0.5 mg	Prior Authorization Required	Medical Necessity	History and physical, and clinical notes of condition being treated, including documentation of previous therapies tried and failed, and proposed treatment plan
Q5121	Injection, infliximab-axxq, biosimilar, (AVSOLA), 10 mg	Prior Authorization Required	Medical Necessity	History and physical, and clinical notes of condition being treated, including documentation of previous therapies tried and failed, and proposed treatment plan
Q5122	Injection, pegfilgrastim-apgf (nyvepria), biosimilar, 0.5 mg	Prior Authorization Required	Medical Necessity	History and physical, and clinical notes of condition being treated, including documentation of previous therapies tried and failed, and proposed treatment plan
Q5123	Injection, rituximab-arrx, biosimilar, (Riabni), 10 mg	Prior Authorization Required	Medical Necessity	History and physical, and clinical notes of condition being treated, including documentation of previous therapies tried and failed, and proposed treatment plan
Q5124	Injection, ranibizumab-nuna, biosimilar, (byooviz), 0.1 mg	Prior Authorization Required	Medical Necessity	History and physical, and clinical notes of condition being treated, including documentation of previous therapies tried and failed, and proposed treatment plan

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Q5125	Injection, filgrastim-ayow, biosimilar, (Releuko), 1 mcg	Prior Authorization Required	Medical Necessity	History and physical, and clinical notes of condition being treated, including documentation of previous therapies tried and failed, and proposed treatment plan
Q5126	Injection, bevacizumab-maly, biosimilar, (Alymsys), 10 mg	Prior Authorization Required	Medical Necessity	History and physical, and clinical notes of condition being treated, including documentation of previous therapies tried and failed, and proposed treatment plan
Q5127	Injection, Pegfilgrastim-fpgk (Stimufend), biosimilar, 0.5 mg	Prior Authorization Required	Medical Necessity	History and physical, and clinical notes of condition being treated, including documentation of previous therapies tried and failed, and proposed treatment plan
Q5128	Injection, Ranibizumab-eqrn (Cimerli), biosimilar, 0.1 mg	Prior Authorization Required	Medical Necessity	History and physical, and clinical notes of condition being treated, including documentation of previous therapies tried and failed, and proposed treatment plan
Q5129	Injection, Bevacizumab-adcd (Vegzelma), biosimilar, 10 mg	Prior Authorization Required	Medical Necessity	History and physical, and clinical notes of condition being treated, including documentation of previous therapies tried and failed, and proposed treatment plan
Q5130	Injection, Pegfilgrastim-pbbk (Fylnetra), biosimilar, 0.5 mg	Prior Authorization Required	Medical Necessity	History and physical, and clinical notes of condition being treated, including documentation of previous therapies tried and failed, and proposed treatment plan
Q5133	Injection, tocilizumab-bavi (tofidence), biosimilar, 1 mg	Prior Authorization Required	Medical Necessity	History and Physical, documentation of medical necessity
Q5134	Injection, natalizumab-sztn (tyruko), biosimilar, 1 mg	Prior Authorization Required	Medical Necessity	History and Physical, documentation of medical necessity
Q5135	Injection, tocilizumab-aazg (tyenne), biosimilar, 1 mg	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
Q5136	Injection, denosumab-bbdz (Jubbonti/Wyost), biosimilar, 1 mg	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, including recent lab work and any other attempted medications and response(s), if applicable
Q5137	Injection, ustekinumab-auub (Wezlana), biosimilar, SC, 1 mg	Prior Authorization Required	Medical Necessity	History and Physical, documentation of medical necessity
Q5138	Injection, ustekinumab-auub (Wezlana), biosimilar, IV, 1 mg	Prior Authorization Required	Medical Necessity	History and Physical, documentation of medical necessity
Q5146	Injection, trastuzumab-strf (hercessi), biosimilar, 10 mg	Prior Authorization Required	Medical Necessity	History and Physical, clinical notes related to a condition being treated, documentation of previous therapies tried and failed.
Q5147	Injection, aflibercept-ayyh (pavblu), biosimilar, 1 mg	Prior Authorization Required	Medical Necessity	History and Physical, documentation of medical necessity, and any failed conservative treatment
Q5148	Injection, filgrastim-txid (nypozi), biosimilar, 1 microgram	Prior Authorization Required	Medical Necessity	Submit history and physical from ordering physician, with Hgb level and transferrin saturation or ferritin level within 1 month of starting treatment, documentation of previous erythropoietin stimulating agent tried and failed.
Q5149	Injection, aflibercept-abzv (Enzeevu), biosimilar, 1 mg	Prior Authorization Required	Medical Necessity	History and physical, clinical notes related to a condition being treated, and documentation of previous therapies tried and failed.
Q5150	Injection, aflibercept-mrbb (Ahzantive), biosimilar, 1 mg	Prior Authorization Required	Medical Necessity	History and physical, clinical notes related to a condition being treated, and documentation of previous therapies tried and failed.
Q5151	Injection, eculizumab-aagh (Epysqli), biosimilar, 2 mg	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity and previously tried therapies
Q5152	Injection, eculizumab-aeeb (Bkemv), biosimilar, 2 mg	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity and previously tried therapies

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Q5153	Injection, aflibercept-yszy (opuviz), biosimilar, 1 mg	Prior Authorization Required	Medical Necessity	History and Physical, clinical notes related to a condition being treated, documentation of previous therapies tried and failed.
Q5155	Injection, aflibercept-jbvf (Yesafili), biosimilar, 1 mg	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, including recent lab work and any other attempted medications and response(s), if applicable
Q5157	Injection, denosumab-bmwo (Stoboclo/Osenvelt), biosimilar, 1 mg	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, including recent lab work and any other attempted medications and response(s), if applicable
Q5158	Injection, denosumab-bnht (Bomyntra/Conexxence), biosimilar, 1 mg	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, including recent lab work and any other attempted medications and response(s), if applicable
Q5159	Injection, denosumab-dssb (Ospomyv/Xbryk), biosimilar, 1 mg	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity, including recent lab work and any other attempted medications and response(s), if applicable
Q5160	Injection, bevacizumab-nwgd (Jobevne), biosimilar, 10 mg	Prior Authorization Required	Medical Necessity	History and physical, including prior treatments and proposed treatment options. Please do not send infusion records.
Q5162	Injection, denosumab-nxxp (bildyos/bilprevda), biosimilar, 1 mg	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
Q5167	Injection, denosumab-qbde (Enoby/Xtrenbo), biosimilar, 1 mg	Pre-Service Review Required	Medical Necessity	History and physical, documentation of medical necessity, including recent lab work and any other attempted medications and response(s), if applicable
Q9001	Assessment by chaplain services	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.

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Q9002	Counseling, individual, by chaplain services	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
Q9003	Counseling, group, by chaplain services	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
Q9004	Department of Veterans Affairs Whole Health Partner Services	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
Q9972	Injection, epoetin beta, 1 microgram, (for ESRD on dialysis)	Advance Benefit Determination (ABD) recommended	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. Allow under age 18.
Q9973	Injection, epoetin beta, 1 microgram, (non-ESRD use)	Advance Benefit Determination (ABD) recommended	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. Allow under age 18.
Q9989	Ustekinumab IV Inj, 1 mg	Advance Benefit Determination (ABD) recommended	Medical Necessity	History and Physical, documentation of medical necessity
Q9996	Injection, ustekinumab-ttwe (Pyzchiva), subcutaneous, 1 mg	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
Q9997	Injection, ustekinumab-ttwe (Pyzchiva), intravenous, 1 mg	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity and previously tried therapies
Q9998	Injection, ustekinumab-aekn (Selarsdi), 1 mg	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity and previously tried therapies
Q9999	Injection, ustekinumab-aauz (Otulfi), biosimilar, 1 mg	Prior Authorization Required	Medical Necessity	History and physical, documentation of medical necessity and previously tried therapies
S0122	INJECTION MENOTROPINS 75 IU	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.
S0126	INJECTION FOLLITROPIN ALFA 75 IU	Prior Authorization Required	Medical Necessity	Submit history and physical, documentation of medical necessity.

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S0128	Injection, follitropin beta, 75 IU	Prior Authorization Required	Potential Contract Exclusion	History and physical, and documentation of infertility, including treatment plan
S0132	Injection, ganirelix acetate, 250 mcg	Prior Authorization Required	Potential Contract Exclusion	History and physical, and documentation of infertility, including treatment plan
S0139	Minoxidil 10mg	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
S0145	Injection, pegylated interferon alfa-2a, 180 mcg per ml	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	For males <18 years: Submit history and physical confirming diagnosis of delay in sexual development and/or puberty; bone age to be assessed, including liver function tests, and hematocrit levels; for males 18 and older: Submit history and physical and baseline with annual PSA for patients over age 40 (prostatectomy excluded from the requirement). For males or females: Monitor heart attack, stroke, and cancer risks, as well as regular monitoring of liver function tests, and hematocrit levels
S0189	Testosterone pellet, 75 mg	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	Submit history and physical, documentation of medical necessity.
S0190	Mifepristone, oral, 200 mg	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
S0191	Misoprostol, oral, 200 mcg	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
S0194	Dialysis/stress vitamin supplement, oral, 100 capsules	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.

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S0199	Medically induced abortion by oral ingestion of medication including all associated services and supplies (e.g., patient counseling, office visits, confirmation of pregnancy by HCG, ultrasound to confirm duration of pregnancy, ultrasound to confirm completion of abortion) except drugs	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
S0207	Paramedic intercept, nonhospital-based ALS service (nonvoluntary), nontransport	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	Submit progress notes for the last 24 hours prior to transport, and physician order, including medical records supporting the rationale for transport
S0208	Paramedic intercept, hospital-based ALS service (nonvoluntary), nontransport	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	Submit progress notes for the last 24 hours prior to transport, and physician order, including medical records supporting the rationale for transport
S0209	Wheelchair van, mileage, per mile	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
S0215	Nonemergency transportation; mileage, per mile	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
S0257	Counseling and discussion regarding advance directives or end of life care planning and decisions, with patient and/or surrogate (list separately in addition to code for appropriate evaluation and management service)	Prior Authorization Required	Medical Necessity	Submit history and physical and documentation of treatment /care plan
S0265	Genetic counseling, under physician supervision, each 15 minutes	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	Submit history and physical, documentation of medical necessity.
S0280	Medical home program, comprehensive care coordination and planning, initial plan	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
S0281	Medical home program, comprehensive care coordination and planning, maintenance of plan	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
S0302	Completed early periodic screening diagnosis and treatment (EPSDT) service (list in addition to code for appropriate evaluation and management service)	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
S0311	Comprehensive management and care coordination for advanced illness, per calendar month	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
S0315	Disease management program; initial assessment and initiation of the program	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
S0316	Disease management program, follow-up/reassessment	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
S0317	Disease management program; per diem	Non-covered Service	Not Covered	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	Not Covered	Considered non-covered unless member's contract indicates coverage.
S0340	Lifestyle modification program for management of coronary artery disease, including all supportive services; first quarter/stage	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
S0341	Lifestyle modification program for management of coronary artery disease, including all supportive services; second or third quarter/stagE	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
S0342	Lifestyle modification program for management of coronary artery disease, including all supportive services; fourth quarter/stage	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
S0353	Treatment planning and care coordination management for cancer initial treatment	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
S0354	Treatment planning and care coordination management for cancer established patient with a change of regimen	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
S0390	Routine foot care; removal and/or trimming of corns, calluses and/or nails and preventive maintenance in specific medical conditions (e.g., diabetes), per visit	Medical necessity review will be performed upon claims submission with supporting documentation.	Medical Necessity	Allow if diagnosis is covered per SBP language; submit history & physical and documentation of medical necessity
S0395	Impression casting of a foot performed by a practitioner other than the manufacturer of the orthotic	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
S0400	Global fee for extracorporeal shock wave lithotripsy treatment of kidney stone(s)	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
S0500	Disposable contact lens, per lens	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	Submit history and physical, documentation of medical necessity.
S0504	Single vision prescription lens (safety, athletic, or sunglass), per lens	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	Submit history and physical, documentation of medical necessity.
S0506	Bifocal vision prescription lens (safety, athletic, or sunglass), per lens	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	Submit history and physical, documentation of medical necessity.
S0508	Trifocal vision prescription lens (safety, athletic, or sunglass), per lens	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	Submit history and physical, documentation of medical necessity.
S0510	Nonprescription lens (safety, athletic, or sunglass), per lens	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
S0512	Daily wear specialty contact lens, per lens	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
S0514	Color contact lens, per lens	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
S0516	Safety eyeglass frames	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
S0518	Sunglasses frames	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
S0580	Polycarbonate lens (list this code in addition to the basic code for the lens)	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	Submit history and physical, documentation of medical necessity.
S0581	Nonstandard lens (list this code in addition to the basic code for the lens)	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
S0590	Integral lens service, miscellaneous services reported separately	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
S0592	Comprehensive contact lens evaluation	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
S0596	Phakic intraocular lens for correction of refractive error	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
S0601	Screening proctoscopy	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
S0620	Routine ophthalmological examination including refraction; new patient	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
S0621	Routine ophthalmological examination including refraction; established patient	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
S0622	Physical exam for college, new or established patient (list separately in addition to appropriate evaluation and management code)	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
S0800	Laser in situ keratomileusis (LASIK)	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
S0810	Photorefractive keratectomy (PRK)	Non-covered Service	Not Covered	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	Not Covered	Considered non-covered unless member's contract indicates coverage.
S1002	Customized item (list in addition to code for basic item)	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.

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S1034	Artificial pancreas device system (e.g., low glucose suspend [LGS] feature) including continuous glucose monitor	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical and documentation of medical necessity, including prior use of inculsin pump therapy
S1035	Sensor; invasive (e.g., subcutaneous), disposable, for use with artificial pancreas device system	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical and documentation of medical necessity, including prior use of inculsin pump therapy
S1036	Transmitter; external, for use with artificial pancreas device system	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical and documentation of medical necessity, including prior use of inculsin pump therapy
S1037	Receiver (monitor); external, for use with artificial pancreas device system	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical and documentation of medical necessity, including prior use of inculsin pump therapy
S2053	Transplantation of small intestine and liver allografts	Prior Authorization Required	Medical Necessity	If transplant approval on record, then provide date of transplant; if no transplant approval on record, then provide history and physical, transplant evaluation, and date of transplant
S2054	Transplantation of multivisceral organs	Prior Authorization Required	Medical Necessity	If transplant approval on record, then provide date of transplant; if no transplant approval on record, then provide history and physical, transplant evaluation, and date of transplant
S2060	Lobar lung transplantation	Prior Authorization Required	Medical Necessity	If transplant approval on record, then provide date of transplant; if no transplant approval on record, then provide history and physical, transplant evaluation, and date of transplant
S2065	Simultaneous pancreas kidney transplantation	Prior Authorization Required	Medical Necessity	If transplant approval on record, then provide date of transplant; if no transplant approval on record, then provide history and physical, transplant evaluation, and date of transplant

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
S2080	Laser-assisted uvulopalatoplasty (LAUP)	Medical necessity review will be performed upon claims submission with supporting documentation	Investigative	History and physical, including sleep study results, and results of CPAP trial
S2095	Transcatheter occlusion or embolization for tumor destruction, percutaneous, any method, using yttrium-90 microspheres	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, and doucmentation of medical necessity including prior treatment regimens
S2102	Islet cell tissue transplant from pancreas; allogeneic	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
S2103	Adrenal tissue transplant to brain	Medical necessity review will be performed upon claims submission with supporting documentation	Investigative	Submit history and physical and documentation of treatment /care plan
S2107	Adoptive immunotherapy i.e. development of specific antitumor reactivity (e.g., tumor-infiltrating lymphocyte therapy) per course of treatment	Prior Authorization Required	Investigative	History and physical, documentation of medical necessity, and treatment plan
S2112	Arthroscopy, knee, surgical for harvesting of cartilage (chondrocyte cells)	Prior Authorization Required	Medical Necessity	History and physical, pre-op evaluations, imaging reports, conservative measures and response, operative/procedure report, anesthesia report, and documentation of medical necessity
S2117	Arthroereisis, subtalar	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
S2120	Low density lipoprotein (LDL) apheresis using heparin-induced extracorporeal LDL precipitation	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
S2140	Cord blood harvesting for transplantation, allogeneic	Prior Authorization Required	Medical Necessity	If transplant approval on record, then provide date of transplant; if no transplant approval on record, then provide history and physical, transplant evaluation, and date of transplant

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S2142	Cord blood-derived stem-cell transplantation, allogeneic	Prior Authorization Required	Medical Necessity	If transplant approval on record, then provide date of transplant; if no transplant approval on record, then provide history and physical, transplant evaluation, and date of transplant
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	If transplant approval on record, then provide date of transplant; if no transplant approval on record, then provide history and physical, transplant evaluation, and date of transplant
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	If transplant approval on record, then provide date of transplant; if no transplant approval on record, then provide history and physical, transplant evaluation, and date of transplant
S2202	Echosclerotherapy	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
S2230	Implantation of magnetic component of semi-implantavle hearing device on ossicles in middle ear	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, documentation of medical necessity, and procedure report
S2260	Induced abortion, 17 to 24 weeks	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
S2265	Induced abortion, 25 to 28 weeks	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
S2266	Induced abortion, 29 to 31 weeks	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
S2267	Induced abortion, 32 weeks or greater	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
S2348	Decompression procedure, percutaneous, of nucleus pulposus of intervertebral disc, using radiofrequency energy, single or multiple levels, lumbar	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, documentation of medical necessity and plan of care

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S2411	FETOSCOP LASER TX TREATMENT-TTTS	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	Submit history and physical, documentation of medical necessity.
S3600	STAT laboratory request	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
S3601	Emergency STAT laboratory charge for patient who is homebound or residing in a nursing facilitY	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
S3650	Saliva test, hormone level; during menopause	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
S3652	SLIVA TST HORMONE LEVL;PRTERM LABR	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
S3800	Genetic testing for amyotrophic lateral sclerosis (ALS)	Prior Authorization Required	Medical Necessity Review Required	History and physical, and chart notes from ordering provider with reason for testing
S3840	DNA analysis for germline mutations of the RET proto-oncogene for susceptibility to multiple endocrine neoplasia type 2	Prior Authorization Required	Medical Necessity Review Required	History and physical, and chart notes from ordering provider with reason for testing
S3841	Genetic testing for retinoblastoma	Prior Authorization Required	Medical Necessity Review Required	History and physical, and chart notes from ordering provider with reason for testing
S3842	Genetic testing for von Hippel-Lindeau disease	Prior Authorization Required	Medical Necessity Review Required	History and physical, and chart notes from ordering provider with reason for testing
S3844	DNA analysis of the connection 26 gene (GJB2) for susceptibility to congenital, profound deafness DNA analysis deafness	Prior Authorization Required	Medical Necessity Review Required	History and physical, and chart notes from ordering provider with reason for testing
S3845	Genetic testing for alpha-thalassemia	Prior Authorization Required	Medical Necessity Review Required	History and physical, and chart notes from ordering provider with reason for testing
S3846	Genetic testing for hemoglobin E beta-thalassemia	Prior Authorization Required	Medical Necessity Review Required	History and physical, and chart notes from ordering provider with reason for testing

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S3849	Genetic testing for Niemann-Pick disease	Prior Authorization Required	Medical Necessity Review Required	History and physical, and chart notes from ordering provider with reason for testing
S3850	Genetic testing for sickle cell anemia	Prior Authorization Required	Medical Necessity Review Required	History and physical, and chart notes from ordering provider with reason for testing
S3852	DNA analysis for APOE essilon 4 allele for susceptibility to Alzheimer's disease	Prior Authorization Required	Medical Necessity Review Required	History and physical, and chart notes from ordering provider with reason for testing
S3853	Genetic testing for myotonic muscular dystrophy	Prior Authorization Required	Medical Necessity	History and physical, and chart notes from ordering provider with reason for testing
S3854	Gene expression profiling panel for use in the management of breast cancer treatment	Prior Authorization Required	Medical Necessity	History and physical, and chart notes from ordering provider with reason for testing
S3861	Genetic testing, sodium channel, voltage-gated, type V, alpha subunit (SCN5A) and variants for suspected Brugada Syndrome	Prior Authorization Required	Medical Necessity	History and physical, and chart notes from ordering provider with reason for testing
S3865	Comprehensive gene sequence analysis for hypertrophic cardiomyopathy	Prior Authorization Required	Medical Necessity	History and physical, and chart notes from ordering provider with reason for testing
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	Medical Necessity	History and physical, and chart notes from ordering provider with reason for testing
S3870	Comparative genomic hybrization (CGH) microarray testing for developmental delay, autism spectrum disorder and/or mental retardation	Prior Authorization Required	Medical Necessity	History and physical, and chart notes from ordering provider with reason for testing
S4011	IN VITRO FERTILIZATION;	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
S4013	COMPLETE CYCLE GIFT CASE RATE	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
S4014	COMPLETE CYCLE ZIFT CASE RATE	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.

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S4015	COMPLETE IVF CYCLE CASE RATE NOS	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
S4016	FROZEN IVF CYCLE CASE RATE	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
S4017	INCPL CYCL TX CANCELD PRIOR TO STIM	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
S4018	FRZN EMB TRANS CANCL CASE RATE	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
S4020	IVF PROC CANCL BEFR ASPIR CASE RATE	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
S4021	IVF PROC CANCL AFTR ASPIR CASE RATE	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
S4022	ASSIST OOCYTE FERTILIZ CASE RATE	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
S4023	DONOR EGG CYCLE INCPL CASE RATE	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
S4025	DONOR SRVC IN VITRO FERTILIZATION	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
S4026	PROCUREMENT DONR SPERM SPERM BANK	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
S4027	STORAGE PREVIOUSLY FROZEN EMBRYOS	Prior Authorization Required	Potential Contract Exclusion	History and physical, and documentation of infertility, including treatment plan
S4028	MICSURG EPIDIDYMAL SPERM ASPIR	Prior Authorization Required	Potential Contract Exclusion	History and physical, documentation of infertility and treatment plan.
S4030	SPERM PROCUREMENT&CRYOPRES; 1 VISIT	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
S4031	SPERM PROCURE&CRYOPRES; SUBSQT VST	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
S4035	Stimulated intrauterine insemination (IUI), case rate	Prior Authorization Required	Potential Contract Exclusion	History and physical, and documentation of infertility, including treatment plan
S4037	CRYOPRESERVD EMBRYO TRNSF CASE RATE	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
S4040	MON & STOR CRYOPRESRV EMBRYOS 30 DA	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.

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S4042	Management of ovulation induction (interpretation of diagnostic tests and studies, nonface-to-face medical management of the patient), per cycle	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
S4990	Nicotine patches, legend	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
S4991	Nicotine patches, nonlegend	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
S5100	Day care services, adult; per 15 minutes	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
S5101	Day care services, adult; per half day	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
S5102	Day care services, adult; per diem	Non-covered Service	Not Covered	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	Not Covered	Considered non-covered unless member's contract indicates coverage.
S5108	Home care training to home care client, 15 min	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
S5109	Home care training to home care client, per session	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
S5110	Home care training, family; per 15 minutes	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
S5111	Home care training, family; per session	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
S5115	Home care training, nonfamily; per 15 minutes	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
S5116	Home care training, nonfamily; per session	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
S5120	Chore services; per 15 minutes	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
S5121	Chore services; per diem	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
S5125	Attendant care services; per 15 minutes	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
S5126	Attendant care services; per diem	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.

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S5130	Homemaker service, NOS; per 15 minutes	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
S5131	Homemaker service, NOS; per diem	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
S5135	Companion care, adult (e.g., IADL/ADL); per 15 minutes	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
S5136	Companion care, adult (e.g., IADL/ADL); per diem	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
S5140	Foster care, adult; per diem	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
S5141	Foster care, adult; per month	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
S5145	Foster care, therapeutic, child; per diem	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
S5146	Foster care, therapeutic, child; per month	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
S5150	Unskilled respite care, not hospice; per 15 minutes	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
S5151	Unskilled respite care, not hospice; per diem	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
S5160	Emergency response system; installation and testing	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
S5161	Emergency response system; service fee, per month (excludes installation and testing)	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
S5162	Emergency response system; purchase only	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
S5165	Home modifications; per service	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
S5170	Home delivered meals, including preparation; per meal	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
S5175	Laundry service, external, professional; per order	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
S5180	Home health respiratory therapy, initial evaluation	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
S5181	Unlisted home health respiratory therapy, nos, per diem	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.

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S5185	Medication reminder service, nonface-to-face; per month	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
S5190	WELLNESS ASSESS PRFRM NON-PHYSICIAN	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
S5199	Personal care item, NOS, each	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
S8055	Ultrasound guidance for multifetal pregnancy reduction(s), technical component (only to be used when the physician doing the reduction procedure does not perform the ultrasound, guidance is included in the CPT code for multifetal pregnancy reduction (59866)	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
S8092	Electron beam computed tomography (also known as ultrafast CT, cine CT)	Prior Authorization Required	Medical Necessity	Submit history and physical and documentation of medical necessity, and procedure/imaging report
S8130	Interferential current stimulator, 2 channel	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, documentation of medical necessity and plan of care
S8131	Interferential current stimulator, 4 channel	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, documentation of medical necessity and plan of care
S8270	Enuresis alarm, using auditory buzzer and/or vibration device	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
S8940	Equestrian/hippotherapy, per session	Non-covered Service	Not Covered	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	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	Submit history and physical, documentation of medical necessity.
S8990	Physical or manipulative therapy performed for maintenance rather than restoration	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
S9001	Home uterine monitor with or without associated nursing services	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
S9002	Intra-vaginal motion sensor system, provides biofeedback for pelvic floor muscle rehabilitation device	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
S9055	Procuren or other growth factor preparation to promote wound healing	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, including previous conservative treatments and surgeries tried
S9056	COMA STIMULATION PER DIEM	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	Submit history and physical, documentation of medical necessity.
S9090	Vertebral axial decompression, per session	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	History and physical, documentation of medical necessity and plan of care
S9110	Telemonitoring of patient in their home, including all necessary equipment; computer system, connections, and software; maintenance; patient education and support; per month	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
S9117	Back school, per visit	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
S9122	Home health aide or certified nurse assistant, providing care in the home; per hour	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
S9125	Respite care, in the home, per diem	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
S9349	Home infusion therapy, tocolytic infusion therapy (drugs and nursing visits coded separately), per diem	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
S9381	Delivery or service to high risk areas requiring escort or extra protection, per visit	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
S9430	Pharmacy compounding and dispensing services	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
S9432	Medical foods for noninborn errors of metabolism	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
S9433	Medical food nutritionally complete, administered orally, providing 100% of nutritional intake	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
S9434	Modified solid food supplements for inborn errors of metabolism	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
S9435	Medical foods for inborn errors of metabolism	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
S9436	Childbirth preparation/Lamaze classes, nonphysician provider, per session	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
S9437	Childbirth refresher classes, nonphysician provider, per session	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
S9438	Cesarean birth classes, nonphysician provider, per session	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
S9439	VBAC (vaginal birth after cesarean) classes, nonphysician provider, per session	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
S9441	Asthma education, nonphysician provider, per session	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
S9442	Birthing classes, nonphysician provider, per session	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
S9444	Parenting classes, nonphysician provider, per session	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
S9445	Patient education, not otherwise classified, nonphysician provider, individual, per session	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
S9446	Patient education, not otherwise classified, nonphysician provider, group, per session	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
S9447	Infant safety (including CPR) classes, nonphysician provider, per session	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
S9449	Weight management classes, nonphysician provider, per session	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
S9451	Exercise classes, nonphysician provider, per session	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
S9454	Stress management classes, nonphysician provider, per session	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
S9472	Cardiac rehabilitation program, nonphysician provider, per diem	Prior Authorization Required	Medical Necessity	History and physical, operative report (if applicable), therapy notes and documentation of medical necessity including reasoning for rehab and treatment plan
S9473	PULM REHAB PROGM NON-PHYS PROV DIEM	Prior Authorization Required	Medical Necessity	History and physical, operative report (if applicable), therapy notes and documentation of medical necessity including reasoning for rehab and treatment plan
S9476	Vestibular rehabilitation program, nonphysician provider, per diem	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
S9482	Family stabilization services, per 15 minutes	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
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	Submit documentation to describe specific services provided; specify procedure performed and treatment plan
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	Not Covered	Considered non-covered unless member's contract indicates coverage.
S9901	Services by a Journal-listed Christian Science nurse, per hour	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
S9960	Ambulance service, conventional air services, nonemergency transport, one way (fixed wing)	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
S9961	Ambulance service, conventional air service, nonemergency transport, one way (rotary wing)	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
S9970	Health club membership, annual	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
S9975	Transplant related lodging, meals and transportation, per diem	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
S9976	Lodging, per diem, not otherwise classified	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
S9977	Meals, per diem, not otherwise specified	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
S9981	MEDICAL RECORDS COPYING FEE ADMIN	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
S9982	MEDICAL RECORDS COPYING FEE-PAGE	Non-covered Service	Not Covered	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	Not Covered	Considered non-covered unless member's contract indicates coverage.
S9988	Services provided as part of a phase I clinical trial	Prior Authorization Required	Potential Contract Exclusion	History and physical, and documentation of medical necessity. If service is not related to CAR T-cell therapy medical necessity review will be performed upon claims submission with supporting documentation.
S9989	Services provided outside of the United States of America (list in addition to code(s) for services(s)	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
S9990	Services provided as part of a Phase II clinical trial	Prior Authorization Required	Potential Contract Exclusion	History and physical, and documentation of medical necessity.If service is not related to CAR T-cell therapy then medical necessity review will be performed upon claims submission with supporting documentation.
S9991	Services provided as part of a phase III clinical trial	Prior Authorization Required	Potential Contract Exclusion	History and physical, and documentation of medical necessity.If service is not related to CAR T-cell therapy then medical necessity review will be performed upon claims submission with supporting documentation.
S9996	Meals for clinical trial participant and one caregiver/companion	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
S9999	Sales tax	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
T1000	Private duty/independent nursing service(s), licensed, up to 15 minutes	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
T1004	Services of a qualified nursing aide, up to 15 minutes	Non-covered Service	Not Covered	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	Not Covered	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	Not Covered	Considered non-covered unless member's contract indicates coverage.
T1012	Alcohol and/or substance abuse services, skills development	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
T1013	Sign language or oral interpretive services, per 15 minutes	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
T1014	Telehealth transmission, per minute, professional services bill separately	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
T1016	Case management, each 15 minutes	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
T1017	Targeted case management, each 15 minutes	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
T1018	School-based individualized education program (IEP) services, bundled	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
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	Not Covered	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	Not Covered	Considered non-covered unless member's contract indicates coverage.

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Code	Description	Plan Review Requirement	Reviewed For	Records Request
T1021	Home health aide or certified nurse assistant, per visit	Non-covered Service	Not Covered	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	Not Covered	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	Not Covered	Considered non-covered unless member's contract indicates coverage.
T1024	Evaluation and treatment by an integrated, specialty team contracted to provide coordinated care to multiple or severely handicapped children, per encounter	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
T1025	Intensive, extended multidisciplinary services provided in a clinic setting to children with complex medical, physical, mental and psychosocial impairments, per diem	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
T1026	Intensive, extended multidisciplinary services provided in a clinic setting to children with complex medical, physical, medical and psychosocial impairments, per hour	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
T1027	Family training and counseling for child development, per 15 minutes	Non-covered Service	Not Covered	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	Not Covered	Considered non-covered unless member's contract indicates coverage.
T1029	Comprehensive environmental lead investigation, not including laboratory analysis, per dwelling	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
T1032	Services performed by a doula birth worker, per 15 minutes	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.

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Code List

Code	Description	Plan Review Requirement	Reviewed For	Records Request
T1033	Services performed by a doula birth worker, per diem	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
T1040	Medicaid certified community behavioral health clinic services, per diem	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
T1041	Medicaid certified community behavioral health clinic services, per month	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
T1505	Electronic medication compliance management device, includes all components and accessories, not otherwise classified	Non-covered Service	Not Covered	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	Not Covered	Considered non-covered unless member's contract indicates coverage.
T2001	Nonemergency transportation; patient attendant/escort	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
T2002	Nonemergency transportation; per diem	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
T2003	Nonemergency transportation; encounter/trip	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
T2004	Nonemergency transport; commercial carrier, multipass	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
T2005	Nonemergency transportation; stretcher van	Non-covered Service	Not Covered	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	Not Covered	Considered non-covered unless member's contract indicates coverage.
T2010	Preadmission screening and resident review (PASRR) Level I identification screening, per screen	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
T2011	Preadmission screening and resident review (PASRR) Level II evaluation, per evaluation	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
T2012	Habilitation, educational; waiver, per diem	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
T2013	Habilitation, educational, waiver; per hour	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
T2014	Habilitation, prevocational, waiver; per diem	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
T2015	Habilitation, prevocational, waiver; per hour	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
T2016	Habilitation, residential, waiver; per diem	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
T2017	Habilitation, residential, waiver; 15 minutes	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
T2018	Habilitation, supported employment, waiver; per diem	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
T2019	Habilitation, supported employment, waiver; per 15 minutes	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
T2020	Day habilitation, waiver; per diem	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
T2021	Day habilitation, waiver; per 15 minutes	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
T2022	Case management, per month	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
T2023	Targeted case management; per month	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
T2024	Service assessment/plan of care development, waiver	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
T2025	Waiver services; not otherwise specified (NOS)	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
T2026	Specialized childcare, waiver; per diem	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
T2027	Specialized childcare, waiver; per 15 minutes	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
T2028	Specialized supply, not otherwise specified, waiver	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
T2029	Specialized medical equipment, not otherwise specified, waiver	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
T2030	Assisted living, waiver; per month	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
T2031	Assisted living; waiver, per diem	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
T2032	Residential care, not otherwise specified (NOS), waiver; per month	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
T2033	Residential care, not otherwise specified (NOS), waiver; per diem	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
T2034	Crisis intervention, waiver; per diem	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
T2035	Utility services to support medical equipment and assistive technology/devices, waiver	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
T2036	Therapeutic camping, overnight, waiver; each session	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
T2037	Therapeutic camping, day, waiver; each session	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
T2038	Community transition, waiver; per service	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
T2039	Vehicle modifications, waiver; per service	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
T2040	Financial management, self-directed, waiver; per 15 minutes	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
T2041	Supports brokerage, self-directed, waiver; per 15 minutes	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
T2047	Habilitation, prevocational, waiver; per 15 minutes	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
T2048	Behavioral health; long-term care residential (nonacute care in a residential treatment program where stay is typically longer than 30 days), with room and board, per diem	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
T2049	Nonemergency transportation; stretcher van, mileage; per mile	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
T2050	Financial management, self-directed, waiver; per diem	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
T2051	Supports brokerage, self-directed, waiver; per diem	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
T2101	Human breast milk processing, storage and distribution only	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.

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Code List

Code	Description	Plan Review Requirement	Reviewed For	Records Request
T4521	Adult sized disposable incontinence product, brief/diaper, small, each	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
T4522	Adult sized disposable incontinence product, brief/diaper, medium, each	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
T4523	Adult sized disposable incontinence product, brief/diaper, large, each	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
T4524	Adult sized disposable incontinence product, brief/diaper, extra large, each	Non-covered Service	Not Covered	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	Not Covered	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	Not Covered	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	Not Covered	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	Not Covered	Considered non-covered unless member's contract indicates coverage.
T4529	Pediatric sized disposable incontinence product, brief/diaper, small/medium size, each	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
T4530	Pediatric sized disposable incontinence product, brief/diaper, large size, each	Non-covered Service	Not Covered	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	Not Covered	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	Not Covered	Considered non-covered unless member's contract indicates coverage.
T4533	Youth sized disposable incontinence product, brief/diaper, each	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
T4534	Youth sized disposable incontinence product, protective underwear/pull-on, each	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
T4535	Disposable liner/shield/guard/pad/undergarment, for incontinence, each	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
T4536	Incontinence product, protective underwear/pull-on, reusable, any size, each	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
T4537	Incontinence product, protective underpad, reusable, bed size, each	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
T4538	Diaper service, reusable diaper, each diaper	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
T4539	Incontinence product, diaper/brief, reusable, any size, each	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
T4540	Incontinence product, protective underpad, reusable, chair size, each	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
T4541	Incontinence product, disposable underpad, large, each	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
T4542	Incontinence product, disposable underpad, small size, each	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
T4543	Disposable incontinence product, brief/diaper, bariatric, each	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
T4544	Adult sized disposable incontinence product, protective underwear/pull-on, above extra large, each	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
T4545	Incontinence product, disposable, penile wrap, each	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
T5999	Supply, not otherwise specified	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	Letter of medical necessity, including member's current medical condition describing functional status and description of equipment provided
T5999	Supply, not otherwise specified	Medical necessity review will be performed upon claims submission with supporting documentation	Medical Necessity	Letter of medical necessity, including member's current medical condition describing functional status and description of equipment provided
V2025	Deluxe frame	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
V2121	Lenticular lens, per lens, single	Advance Benefit Determination (ABD) recommended	Potential Contract Exclusion	Submit history and physical, documentation of medical necessity.

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Code List

Code	Description	Plan Review Requirement	Reviewed For	Records Request
V2199	Not otherwise classified, single vision lens	Advance Benefit Determination (ABD) recommended	Potential Contract Exclusion	Submit history and physical, documentation of medical necessity.
V2299	Specialty bifocal (by report)	Advance Benefit Determination (ABD) recommended	Potential Contract Exclusion	Submit history and physical, documentation of medical necessity.
V2321	Lenticular lens, per lens, trifocal	Advance Benefit Determination (ABD) recommended	Potential Contract Exclusion	Submit history and physical, documentation of medical necessity.
V2499	Variable sphericity lens, other type	Advance Benefit Determination (ABD) recommended	Potential Contract Exclusion	Submit history and physical, documentation of medical necessity.
V2524	Contact lens, hydrophilic, spherical, photochromic additive, per lens	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
V2599	Contact lens, other type	Advance Benefit Determination (ABD) recommended	Potential Contract Exclusion	Submit history and physical, documentation of medical necessity.
V2600	Hand held low vision aids and other nonspectacle mounted aids	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
V2610	Single lens spectacle mounted low vision aids	Non-covered Service	Not Covered	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	Not Covered	Considered non-covered unless member's contract indicates coverage.
V2702	Deluxe lens feature	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
V2744	Tint, photochromatic, per lens	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
V2745	Addition to lens; tint, any color, solid, gradient or equal, excludes photochromatic, any lens material, per lens	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
V2750	Antireflective coating, per lens	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
V2755	U-V lens, per lens	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
V2756	Eye glass case	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
V2760	Scratch resistant coating, per lens	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.

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V2761	Mirror coating, any type, solid, gradient or equal, any lens material, per lens	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
V2762	Polarization, any lens material, per lens	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
V2781	Progressive lens, per lens	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
V2782	Lens, index 1.54 to 1.65 plastic or 1.60 to 1.79 glass, excludes polycarbonate, per lens	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
V2783	Lens, index greater than or equal to 1.66 plastic or greater than or equal to 1.80 glass, excludes polycarbonate, per lens	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
V2784	Lens, polycarbonate or equal, any index, per lens	Advance Benefit Determination (ABD) recommended	Potential Contract Exclusion	Submit history and physical, documentation of medical necessity.
V2786	Specialty occupational multifocal lens, per lens	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
V2787	Astigmatism correcting function of intraocular lens	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
V2788	Presbyopia correcting function of intraocular lens	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
V2797	Vision supply, accessory and/or service component of another HCPCS vision code	Advance Benefit Determination (ABD) recommended	Medical Necessity	Please submit the clinical notes, the description for V2797, and the medical necessity of the services
V2799	Vision item or service, miscellaneous	Advance Benefit Determination (ABD) recommended	Potential Contract Exclusion	Submit history and physical, documentation of medical necessity.
V5011	Fitting/orientation/checking of hearing aid	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
V5014	Repair/modification of a hearing aid	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
V5020	Conformity evaluation	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
V5030	Hearing aid, monaural, body worn, air conduction	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
V5040	Hearing aid, monaural, body worn, bone conduction	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
V5050	Hearing aid, monaural, in the ear	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.

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V5060	Hearing aid, monaural, behind the ear	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
V5070	Glasses, air conduction	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
V5080	Glasses, bone conduction	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
V5090	Dispensing fee, unspecified hearing aid	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
V5095	Semi-implantable middle ear hearing prosthesis	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
V5100	Hearing aid, bilateral, body worn	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
V5110	Dispensing fee, bilateral	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
V5120	Binaural, body	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
V5130	Binaural, in the ear	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
V5140	Binaural, behind the ear	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
V5150	Binaural, glasses	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
V5160	Dispensing fee, binaural	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
V5171	Hearing aid, contralateral routing device, monaural, in the ear (ITE)	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
V5172	Hearing aid, contralateral routing device, monaural, in the canal (ITC)	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
V5181	Hearing aid, contralateral routing device, monaural, behind the ear (BTE)	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
V5190	Hearing aid, contralateral routing, monaural, glasses	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
V5200	Dispensing fee, contralateral, monaural	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
V5211	Hearing aid, contralateral routing system, binaural, ITE/ITE	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.

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V5212	Hearing aid, contralateral routing system, binaural, ITE/ITC	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
V5213	Hearing aid, contralateral routing system, binaural, ITE/BTE	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
V5214	Hearing aid, contralateral routing system, binaural, ITC/ITC	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
V5215	Hearing aid, contralateral routing system, binaural, ITC/BTE	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
V5221	Hearing aid, contralateral routing system, binaural, BTE/BTE	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
V5230	Hearing aid, contralateral routing system, binaural, glasses	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
V5240	Dispensing fee, contralateral routing system, binaural	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
V5241	Dispensing fee, monaural hearing aid, any type	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
V5242	Hearing aid, analog, monaural, CIC (completely in the ear canal)	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
V5244	Hearing aid, digitally programmable analog, monaural, CIC	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
V5245	Hearing aid, digitally programmable, analog, monaural, ITC	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
V5246	Hearing aid, digitally programmable analog, monaural, ITE (in the ear)	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
V5247	Hearing aid, digitally programmable analog, monaural, BTE (behind the ear)	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
V5248	Hearing aid, analog, binaural, CIC	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
V5249	Hearing aid, analog, binaural, ITC	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
V5250	Hearing aid, digitally programmable analog, binaural, CIC	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
V5251	Hearing aid, digitally programmable analog, binaural, ITC	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
V5252	Hearing aid, digitally programmable, binaural, ITE	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.

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V5253	Hearing aid, digitally programmable, binaural, BTE	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
V5254	Hearing aid, digital, monaural, CIC	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
V5255	Hearing aid, digital, monaural, ITC	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
V5256	Hearing aid, digital, monaural, ITE	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
V5257	Hearing aid, digital, monaural, BTE	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
V5258	Hearing aid, digital, binaural, CIC	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
V5259	Hearing aid, digital, binaural, ITC	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
V5260	Hearing aid, digital, binaural, ITE	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
V5261	Hearing aid, digital, binaural, BTE	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
V5262	Hearing aid, disposable, any type, monaural	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
V5263	Hearing aid, disposable, any type, binaural	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
V5264	Ear mold/ INSERT, not disposable, any type	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
V5265	Ear mold/ INSERT, disposable, any type	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
V5266	Battery for use in hearing device	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
V5267	Hearing aid or assistive listening device/supplies/accessories, not otherwise specified	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
V5268	Assistive listening device, telephone amplifier, any type	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
V5269	Assistive listening device, alerting, any type	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
V5270	Assistive listening device, television amplifier, any type	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.

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V5271	Assistive listening device, television caption decoder	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
V5272	Assistive listening device, TDD	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
V5273	Assistive listening device, for use with cochlear implant	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
V5274	Assistive listening device, not otherwise specified	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
V5275	Ear impression, each	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
V5281	Assistive listening device, personal FM/DM system, monaural (1 receiver, transmitter, microphone), any type	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
V5282	Assistive listening device, personal FM/DM system, binaural (2 receivers, transmitter, microphone), any type	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
V5283	Assistive listening device, personal FM/DM neck, loop induction receiver	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
V5284	Assistive listening device, personal FM/DM, ear level receiver	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
V5285	Assistive listening device, personal FM/DM, direct audio input receiver	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
V5286	Assistive listening device, personal blue tooth FM/DM receiver	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
V5287	Assistive listening device, personal FM/DM receiver, not otherwise specified	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
V5288	Assistive listening device, personal FM/DM transmitter assistive listening device	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
V5289	Assistive listening device, personal FM/DM adapter/boot coupling device for receiver, any type	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
V5290	Assistive listening device, transmitter microphone, any type	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
V5298	Hearing aid, not otherwise classified	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.

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V5299	Hearing service, miscellaneous	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
V5362	Speech screening	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.
V5363	Language screening	Non-covered Service	Not Covered	Considered non-covered unless member's contract indicates coverage.