HIGHMARK . . .

2024 Prior Authorization List

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

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

Prior authorizations are required for:

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

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

Highmark Health Options is an independent licensee of the Blue Cross Blue Shield Association, an association of independent Blue Cross Blue Shield Plans.

Code	Code Description	Prior Authorization Requirement	Referenced Policy, If applicable	Vendor Review Required
0100	All Inclusive Rate-All-inclusive room and board plus ancillary	Prior authorization is required. Coverage is limited to LTSS members.		
0101	All Inclusive Rate-All-inclusive room and board	Prior authorization is required. Coverage is limited to LTSS members.		
00104	Anesthesia for electroconvulsive therapy	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1162 Electroconvulsive Therapy	
0114	Inpatient (IP) Acute Psychiatric	Prior authorization is required. Reference policies for additional information.	HHO-DE-RP-1005 Facility-Based Behavioral Health Services	
0120	Room & Board Semiprivate (Two Beds)-General Classification	For Long Term Acute Care, prior authorization is required and member must meet medical		
		necessity criteria. Concurrent reviews are required every 3-7 days.		
0124	Inpatient (IP) Acute Psychiatric (semi-private two bed)	Prior authorization is required. Reference policies for additional information.	HHO-DE-RP-1005 Facility-Based Behavioral Health Services	
0129	Room & Board-Semiprivate (Two-Beds)-Other	Prior authorization is required. Coverage is limited to LTSS members.		
00170	Anesthesia for procedures on the head	Prior authorization is required.	HHO-DE-RP-1004 Dental Services Under the Medical Benefit	
0190	Subacute Care-General	Prior authorization is required. Skilled nursing benefit is limited to 30 days per calendar year.		
0-0-	Subacute Care-Level I	Prior authorization is required. Skilled nursing benefit is limited to 30 days per calendar year.		
0192	Subacute Care-Level II	Prior authorization is required. Skilled nursing benefit is limited to 30 days per calendar year.		
0193	Subacute Care-Level III	Prior authorization is required. Skilled nursing benefit is limited to 30 days per calendar year.		
0194	Subacute Care-Level IV	Prior authorization is required. Skilled nursing benefit is limited to 30 days per calendar year.		
0199	Subacute Care-Other Subacute Care	Prior authorization is required. Coverage is limited to LTSS members.		
0651	Hospice Service-Routine Home Care	Prior authorization is required.		
0652	Hospice Service-Continuous Home Care	Prior authorization is required.		
0655	Hospice Service-Inpatient Respite Care	Prior authorization is required.	ļ	
0656	Hospice Service-General Inpatient Care Nonrespite	Prior authorization is required.	ļ	
0657	Hospice Service-Physician Services	Prior authorization is required.		
0658	Hospice Service-Hospice Room & Board-Nursing Facility	Prior authorization is required. Coverage is limited to LTSS members.		
0912	Behavioral Health Treatment/Services-Extension of 090X-Partial HospitalizationLess Intensive	Prior authorization is required. Reference policies for additional information.	HHO-DE-RP-1005 Facility-Based Behavioral Health Services	
0913	Behavioral Health Treatment/Services-Extension of 090X-Partial HospitalizationIntensive	Prior authorization is required. Reference policies for additional information.	HHO-DE-RP-1005 Facility-Based Behavioral Health Services	
01999	Unlisted anesthesia procedure(s)	Prior authorization is required.		
10040	Acne surgery (eg, marsupialization, opening or removal of multiple milia, comedones, cysts, pustules)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1130 Removal of Benign or Premalignant Skin Lesions	
11200	Removal of skin tags, multiple fibrocutaneous tags, any area; up to and including 15 lesions	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1130 Removal of Benign or Premalignant Skin Lesions	
11201	Removal of skin tags, multiple fibrocutaneous tags, any area; each additional 10 lesions, or part thereof (List separately in addition to code for primary procedure)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1130 Removal of Benign or Premalignant Skin Lesions	
11300	Shaving of epidermal or dermal lesion, single lesion, trunk, arms or legs; lesion diameter 0.5 cm or less	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1130 Removal of Benign or Premalignant Skin Lesions	
11301	Shaving of epidermal or dermal lesion, single lesion, trunk, arms or legs; lesion diameter 0.6 to 1.0 cm	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1130 Removal of Benign or Premalignant Skin Lesions	
11302	Shaving of epidermal or dermal lesion, single lesion, trunk, arms or legs; lesion diameter 1.1 to 2.0 cm	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1130 Removal of Benign or Premalignant Skin Lesions	
11303	Shaving of epidermal or dermal lesion, single lesion, trunk, arms or legs; lesion diameter over 2.0 cm	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1130 Removal of Benign or Premalignant Skin Lesions	
11305	Shaving of epidermal or dermal lesion, single lesion, scalp, neck, hands, feet, genitalia; lesion diameter 0.5 cm or less	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1130 Removal of Benign or Premalignant Skin Lesions	
11306	Shaving of epidermal or dermal lesion, single lesion, scalp, neck, hands, feet, genitalia; lesion diameter 0.6 to 1.0 cm	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1130 Removal of Benign or Premalignant Skin Lesions	
11307	Shaving of epidermal or dermal lesion, single lesion, scalp, neck, hands, feet, genitalia; lesion diameter 1.1 to 2.0 cm	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1130 Removal of Benign or Premalignant Skin Lesions	
11308	Shaving of epidermal or dermal lesion, single lesion, scalp, neck, hands, feet, genitalia; lesion diameter over 2.0 cm	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1130 Removal of Benign or Premalignant Skin Lesions	
11310	Shaving of epidermal or dermal lesion, single lesion, face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 0.5 cm or less	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1130 Removal of Benign or Premalignant Skin Lesions	
11311	Shaving of epidermal or dermal lesion, single lesion, face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 0.6 to 1.0 cm	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1130 Removal of Benign or Premalignant Skin Lesions	
11312	Shaving of epidermal or dermal lesion, single lesion, face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 1.1 to 2.0 cm	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1130 Removal of Benign or Premalignant Skin Lesions	
11313	Shaving of epidermal or dermal lesion, single lesion, face, ears, eyelids, nose, lips, mucous membrane; lesion diameter over 2.0 cm	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1130 Removal of Benign or Premalignant Skin Lesions	
11400	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter 0.5 cm or less	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1130 Removal of Benign or Premalignant Skin Lesions	
11401	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter 0.6 to 1.0 cm	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1130 Removal of Benign or Premalignant Skin Lesions	
11402	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter 1.1 to 2.0 cm	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1130 Removal of Benign or Premalignant Skin Lesions	
11403	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter 2.1 to 3.0 cm	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1130 Removal of Benign or Premalignant Skin Lesions	
11406	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter over 4.0 cm	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1130 Removal of Benign or Premalignant Skin Lesions	

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11440 face 11441 Excision 11442 Excision 11443 Excision 11443 Excision 11444 Excision 11444 Excision 11446 Excision 11920 Tattooin 11921 Tattooin 11922 skin 11950 11951 11952 11952	sion, other benign lesion including margins, except skin tag (unless listed elsewhere), ace, ears, eyeilds, nose, lips, mucous membrane; excised diameter 0.5 cm or less sion, other benign lesion including margins, except skin tag (unless listed elsewhere), ace, ears, eyeilds, nose, lips, mucous membrane; excised diameter 0.6 to 1.0 cm sion, other benign lesion including margins, except skin tag (unless listed elsewhere), ace, ears, eyeilds, nose, lips, mucous membrane; excised diameter 0.6 to 1.0 cm sion, other benign lesion including margins, except skin tag (unless listed elsewhere), ace, ears, eyeilds, nose, lips, mucous membrane; excised diameter 1.1 to 2.0 cm sion, other benign lesion including margins, except skin tag (unless listed elsewhere), ace, ears, eyeilds, nose, lips, mucous membrane; excised diameter 3.1 to 4.0 cm sion, other benign lesion including margins, except skin tag (unless listed elsewhere), face, ears, eyeilds, nose, lips, mucous membrane; excised diameter 3.1 to 4.0 cm sion, other benign lesion including margins, except skin tag (unless listed elsewhere), face, ears, eyeilds, nose, lips, mucous membrane; excised diameter 0.0 cm excised diameter over 4.0 cm skin, including micropigmentation; 6.0 sq cm or less skin, including micropigmentation; 6.1 to 20.0 sq cm oling, intradermal introduction of insoluble opaque pigments to correct color defects of skin, including micropigmentation; 6.1 to 20.0 sq cm oling, intradermal introduction of consoluble opaque pigments to correct color defects of skin, including micropigmentation; 6.1 to 20.0 sq cm oling, intradermal introduction of consoluble opaque pigments to correct color defects of skin, including micropigmentation; 6.1 to 20.0 sq cm oling, intradermal introduction of condor for primary procedure) (List Separately in addition to code for primary procedure)	Prior authorization is required. Reference policies for additional information. Prior authorization is required. Reference policies for additional information. Prior authorization is required. Reference policies for additional information. Prior authorization is required. Reference policies for additional information. Prior authorization is required. Reference policies for additional information. Prior authorization is required. Reference policies for additional information. Prior authorization is required. Reference policies for additional information. Prior authorization is required and medical necessity criteria must be met. Reference policies for additional information. Prior authorization is required and medical necessity criteria must be met. Reference policies for additional information.	HHO-DE-MP-1130 Removal of Benign or Premalignant Skin Lesions HHO-DE-MP-1130 Removal of Benign or Premalignant Skin Lesions HHO-DE-MP-1027 Breast Reconstructive Surgery	
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11442 Excision fac Excision 11443 Excision fac 11444 Excision fac 11446 Excision fac 11920 Tattooin 11921 Tattooin 11922 Skin 11950 11951 11952 11952	sion, other benign lesion including margins, except skin tag (unless listed elsewhere), äce, ears, eyelids, nose, lips, mucous membrane; excised diameter 1.1 to 2.0 cm sion, other benign lesion including margins, except skin tag (unless listed elsewhere), äce, ears, eyelids, nose, lips, mucous membrane; excised diameter 2.1 to 3.0 cm sion, other benign lesion including margins, except skin tag (unless listed elsewhere), äce, ears, eyelids, nose, lips, mucous membrane; excised diameter 2.1 to 4.0 cm sion, other benign lesion including margins, except skin tag (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; excised diameter 0.4 to 4.0 cm sion, other benign lesion including margins, except skin tag (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; excised diameter over 4.0 cm ping, intradermal introduction of insoluble opaque pigments to correct color defects of skin, including micropigmentation; 6.0 sq cm or less sing, intradermal introduction of insoluble opaque pigments to correct color defects of skin, including micropigmentation; 6.1 to 20.0 sq cm ping, intradermal introduction of insoluble opaque pigments to correct color defects of skin, including micropigmentation; 6.1 to 20.0 sq cm, or part thereof (List separately in addition to code for pimrary procedure)	Prior authorization is required. Reference policies for additional information. Prior authorization is required. Reference policies for additional information. Prior authorization is required. Reference policies for additional information. Prior authorization is required and medical necessity criteria must be met. Reference policies for additional information. Prior authorization is required and medical necessity criteria must be met. Reference policies for additional information.	HHO-DE-MP-1130 Removal of Benign or Premalignant Skin Lesions HHO-DE-MP-1130 Removal of Benign or Premalignant Skin Lesions HHO-DE-MP-1130 Removal of Benign or Premalignant Skin Lesions HHO-DE-MP-1130 Removal of Benign or Premalignant Skin Lesions HHO-DE-MP-1027 Breast Reconstructive Surgery	
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11444 Excision fac 11446 Excision 11920 Tattooin 11921 Tattooin 11921 Tattooin 11922 Skin 11950 11951 11952 11952	sion, other benign lesion including margins, except skin tag (unless listed elsewhere), ace, ears, eyelids, nose, lips, mucous membrane; excised diameter 3.1 to 4.0 cm sion, other benign lesion including margins, except skin tag (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; excised diameter over 4.0 cm aing, intradermal introduction of insoluble opaque pigments to correct color defects of skin, including micropigmentation; 6.0 sq cm or less skin, including micropigmentation; 6.1 to 20.0 sq cm oing, intradermal introduction of insoluble opaque pigments to correct color defects of skin, including micropigmentation; 6.1 to 20.0 sq cm oing, intradermal introduction of insoluble opaque pigments to correct color defects of kin, including micropigmentation; 6.1 to 20.0 sq cm, or part thereof (List separately in addition to code for pimary procedure)	Prior authorization is required. Reference policies for additional information. Prior authorization is required and medical necessity criteria must be met. Reference policies for additional information. Prior authorization is required and medical necessity criteria must be met. Reference policies for additional information.	HHO-DE-MP-1130 Removal of Benign or Premalignant Skin Lesions HHO-DE-MP-1130 Removal of Benign or Premalignant Skin Lesions HHO-DE-MP-1027 Breast Reconstructive Surgery	
11446 Excision factoria 11920 Tattooin 11921 Tattooin 11921 Tattooin 11922 Tattooin 11950 11951 11952 11952	sion, other benign lesion including margins, except skin tag (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; excised diameter over 4.0 cm sing, intradermal introduction of insoluble opaque pigments to correct color defects of skin, including micropigmentation; 6.0 sq cm or less sing, intradermal introduction of insoluble opaque pigments to correct color defects of skin, including micropigmentation; 6.1 to 20.0 sq cm sing, intradermal introduction of insoluble opaque pigments to correct color defects of kin, including micropigmentation; 6.1 to 20.0 sq cm part thereof less of the state of the state of the state of the state of the state separately in addition to code for primary procedure)	Prior authorization is required and medical necessity criteria must be met. Reference policies for additional information. Prior authorization is required and medical necessity criteria must be met. Reference policies for additional information.	HHO-DE-MP-1130 Removal of Benign or Premalignant Skin Lesions HHO-DE-MP-1027 Breast Reconstructive Surgery	
11920 Tattooin 11921 Tattooin 11922 Tattooin 11920 Tattooin 11920 Tattooin 11950 11951 11952 11952	oing, intradermal introduction of insoluble opaque pigments to correct color defects of skin, including micropigmentation; 6.0 s q cm or less oing, intradermal introduction of insoluble opaque pigments to correct color defects of skin, including micropigmentation; 6.1 to 20.0 s q cm oing, intradermal introduction of insoluble opaque pigments to correct color defects of kin, including micropigmentation; 20.0 sq cm, or part thereof (List separately in addition to code for primary procedure)	additional information. Prior authorization is required and medical necessity criteria must be met. Reference policies for additional information.	HHO-DE-MP-1027 Breast Reconstructive Surgery	
11921 Tattooin skin 11920 11950 11951 11952	sing, intradermal introduction of insoluble opaque pigments to correct color defects of skin, including micropigmentation; 6.1 to 20.0 sq cm sing, intradermal introduction of insoluble opaque pigments to correct color defects of kin, including micropigmentation; each additional 20.0 sq cm, or part thereof (List separately in addition to code for primary procedure)	Prior authorization is required and medical necessity criteria must be met. Reference policies for additional information.	HHO-DE-MP-1027 Breast Reconstructive Surgery	
11922 skin 11950 11951 11952	bing, intradermal introduction of insoluble opaque pigments to correct color defects of kin, including micropigmentation; each additional 20.0 sq cm, or part thereof (List separately in addition to code for primary procedure)			
11951 11952		Prior authorization is required and medical necessity criteria must be met. Reference policies for additional information.	HHO-DE-MP-1027 Breast Reconstructive Surgery	
11951 11952	Subcutaneous injection of filling material (eg, collagen); 1 cc or less	Prior authorization is required and medical necessity criteria must be met.		
11952	Subcutaneous injection of filling material (eg, collager); 1:0:0 in its s	Prior authorization is required and medical necessity criteria must be met.		
	Subcutaneous injection of filling material (eg, collagen); 5.1 to 10.0 cc	Prior authorization is required and medical necessity criteria must be met.		
	Subcutaneous injection of filling material (eg, collagen); 5.1 to 10.0 cc	Prior authorization is required and medical necessity criteria must be met.		
	sertion of tissue expander(s) for other than breast, including subsequent expansion	Prior authorization is required and medical necessity effective meters	HHO-DE-MP-1216 Gender Affirmation Services	
11980 Inser 11970		Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1216 Gender Affirmation Services	
	Replacement of tissue expander with permanent testicular insertion utaneous hormone pellet implantation (implantation of estradiol and/or testosterone pellets beneath the skin)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1033 Implantable Hormone Replacement Pellets	
14000	Adjacent tissue transfer or rearrangement, trunk; defect 10 sq. cm or less	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1216 Gender Affirmation Services	
	djacent tissue transfer or rearrangement, trunk; defect 10.1 sq. cm to 30.0 sq. cm	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1216 Gender Affirmation Services	
	acent tissue transfer or rearrangement, forehead, cheeks, chin, mouth, neck, axillae,	Filor autionization is required. Reference policies for additional mormation.	TITIO-DE-WF-1210 Gender Ammation Services	
14041 Adjace	genitalia, hands and/or feet; defect 10.1 sq. cm to 30.0 sq. cm	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1216 Gender Affirmation Services	
15150	Tissue cultured skin autograft, trunk, arms, legs; first 25 sq cm or less	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1257 Bioengineered Skin and Skin Replacement Therapy	
15151	ssue cultured skin autograft, trunk, arms, legs; additional 1 sq cm to 75 sq cm (List separately in addition to code for primary procedure)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1257 Bioengineered Skin and Skin Replacement Therapy	
15152 addit	ssue cultured skin autograft, trunk, arms, legs; each additional 100 sq cm, or each Iditional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1257 Bioengineered Skin and Skin Replacement Therapy	
15155 Tissu	sue cultured skin autograft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet and/or multiple digits; first 25 sq cm or less	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1257 Bioengineered Skin and Skin Replacement Therapy	
	sue cultured skin autograft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, ands, feet and/or multiple digits; additional 1 sq cm to 75 sq cm (List separately in addition to code for primary procedure)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1257 Bioengineered Skin and Skin Replacement Therapy	
15157 hands, fe	sue cultured skin autograft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, , feet and/or multiple digits; each additional 100 sq cm, or each additional 1% of body of infants and children, or part thereof (List separately in addition to code for primary procedure)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1257 Bioengineered Skin and Skin Replacement Therapy	
15271 Applicat	cation of skin substitute graft to trunk, arms, legs, total wound surface area up to 100 sq cm; first 25 sq cm or less wound surface area	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1257 Bioengineered Skin and Skin Replacement Therapy	
	cation of skin substitute graft to trunk, arms, legs, total wound surface area up to 100 cm; each additional 25 sq cm wound surface area, or part thereof (List separately in addition to code for primary procedure)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1257 Bioengineered Skin and Skin Replacement Therapy	
	lication of skin substitute graft to trunk, arms, legs, total wound surface area greater n or equal to 100 sq cm; first 100 sq cm wound surface area, or 1% of body area of infants and children	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1257 Bioengineered Skin and Skin Replacement Therapy	
15274 than or	lication of skin substitute graft to trunk, arms, legs, total wound surface area greater or equal to 100 sq cm; each additional 100 sq cm wound surface area, or part thereof, h additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1257 Bioengineered Skin and Skin Replacement Therapy	

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

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15835	Excision, excessive skin and subcutaneous tissue (includes lipectomy); buttock	Prior authorization is required and medical necessity criteria must be met. Cosmetic procedures are a non-covered service.		
15836	Excision, excessive skin and subcutaneous tissue (includes lipectomy); arm	Prior authorization is required and medical necessity criteria must be met. Cosmetic procedures are a non-covered service.		
15837	Excision, excessive skin and subcutaneous tissue (includes lipectomy); forearm or hand	Prior authorization is required and medical necessity criteria must be met. Cosmetic procedures are a non-covered service.		
15838	Excision, excessive skin and subcutaneous tissue (includes lipectomy); submental fat pad	Prior authorization is required and medical necessity criteria must be met. Cosmetic procedures are a non-covered service.		
15839	Excision, excessive skin and subcutaneous tissue (includes lipectomy); other area	Prior authorization is required and medical necessity criteria must be met. Cosmetic procedures are a non-covered service. Reference policies for additional information.	HHO-DE-MP-1137 Labiaplasty	
15847	Excision, excessive skin and subcutaneous tissue (includes lipectomy), abdomen (eg, abdominoplasty) (includes unbilical transposition and fascial plication) (List separately in	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1003 Abdominoplasty and Panniculectomy	
15876	addition to code for primary procedure) Suction assisted lipectomy; head and neck	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1216 Gender Affirmation Services	
		Prior authorization is required and medical necessity criteria must be met. Cosmetic procedures		
15877	Suction assisted lipectomy; trunk	are a non-covered service.		
15878	Suction assisted lipectomy; upper extremity	Prior authorization is required and medical necessity criteria must be met. Cosmetic procedures are a non-covered service. Reference policies for additional information.	HHO-DE-MP-1137 Hyperhidrosis	
15879	Suction assisted lipectomy; lower extremity	Prior authorization is required and medical necessity criteria must be met. Cosmetic procedures are a non-covered service.		
15999	Unlisted procedure, excision pressure ulcer	Prior authorization is required.		
17000	Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), premalignant lesions (eg, actinic keratoses); first lesion	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1130 Removal of Benign or Premalignant Skin Lesions	
17003	Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), premalignant lesions (eg, actinic keratoses); second through 14 lesions, each (List separately in addition to code for first lesion)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1130 Removal of Benign or Premalignant Skin Lesions	
17004	Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), premalignant lesions (eg, actinic keratoses), 15 or more lesions	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1130 Removal of Benign or Premalignant Skin Lesions	
17106	Destruction of cutaneous vascular proliferative lesions (eg, laser technique); less than 10 sq cm	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1100 Surgical Treatment of Varicose Veins	
17107	Destruction of cutaneous vascular proliferative lesions (eg, laser technique); 10.0 to 50.0 sq cm	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1100 Surgical Treatment of Varicose Veins	
17108	Destruction of cutaneous vascular proliferative lesions (eg, laser technique); over 50.0 sq cm	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1100 Surgical Treatment of Varicose Veins	
17110	Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical		HHO-DE-MP-1130 Removal of Benign or Premalignant Skin	
17110	curettement), of benign lesions other than skin tags or cutaneous vascular proliferative lesions; up to 14 lesions	Prior authorization is required. Reference policies for additional information.	Lesions	
17111	Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), of benign lesions other than skin tags or cutaneous vascular proliferative lesions; 15 or more lesions	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1130 Removal of Benign or Premalignant Skin Lesions	
17311	Mohs micrographic technique, including removal of all gross tumor, surgical excision of tissue specimens, mapping, color coding of specimens, microscopic examination of specimens by the surgeon and histopathologic preparation including routine stain(s) (eg, hematoxylin and eosin, toluidine blue), head, neck, hands, feet, genitalia, or any location with surgery directly involving muscle, cartilage, bone, tendon, major nerves, or vessels; first stage, up to 5 tissue blocks	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1034 Treatment of Malignant Skin Lesions	
17312	Mohs micrographic technique, including removal of all gross tumor, surgical excision of tissue specimens, mapping, color coding of specimens, microscopic examination of specimens by the surgeon and histopathologic preparation including routine stain(s) (sg, hematowjin and eosin, toluidine blue), head, neck, hands, feet, genitalia, or any location with surgery directly involving muscle, cartilage, bone, tendon, major nerves, or vessels; each additional stage after the first stage, up to 5 tissue blocks (List separately in addition to code for primary procedure)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1034 Treatment of Malignant Skin Lesions	
17313	Mohs micrographic technique, including removal of all gross tumor, surgical excision of tissue specimens, mapping, color coding of specimens, microscopic examination of specimens by the surgeon and histopathologic preparation including routine stain(s) (eg, hematoxylin and eosin, toluidine blue), of the trunk, arms, or legs; first stage, up to 5 tissue blocks	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1034 Treatment of Malignant Skin Lesions	
17314	Mohs micrographic technique, including removal of all gross tumor, surgical excision of tissue specimens, mapping, color coding of specimens, microscopic examination of specimens by the surgeon and histopathologic preparation including routine stain(s) (eg, hematoxylin and eosin, toluidine blue), of the trunk, arms, or legs; each additional stage after the first stage, up to 5 tissue blocks (List separately in addition to code for primary procedure)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1034 Treatment of Malignant Skin Lesions	
17315	Mohs micrographic technique, including removal of all gross tumor, surgical excision of tissue specimens, mapping, color coding of specimens, microscopic examination of specimens by the surgeon and histopathologic preparation including routine stain(s) (sg, hematoxylin and eosin, toluidine blue), each additional block after the first 5 tissue blocks, any stage (List separately in addition to code for primary procedure)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1034 Treatment of Malignant Skin Lesions	
17999	Unlisted procedure: Skin, mucous membrane and subcutaneous tissue	Prior authorization is required. Reference policies for additional information. DE-MP-1137 Hyperhidrosis Prior authorization is required for not otherwise classified codes.		
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19105	Ablation, cryosurgical, of fibroadenoma, including ultrasound guidance, each fibroadenoma	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1218 Radiofrequency Ablation of Miscellaneous Solid Tumors	
19301	Mastectomy, partial (eg, lumpectomy, tylectomy, quadrantectomy, segmentectomy);	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1027 Breast Reconstructive Surgery	
19302	Mastectomy, partial (eg, lumpectomy, tylectomy, quadrantectomy, segmentectomy); with axillary lymphadenectomy	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1027 Breast Reconstructive Surgery	
19303	Mastectomy, simple, complete	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1027 Breast Reconstructive Surgery	
19305	Mastectomy, radical, including pectoral muscles, axillary lymph nodes	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1027 Breast Reconstructive Surgery	
19306	Mastectomy, radical, including pectoral muscles, axillary and internal mammary lymph	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1027 Breast Reconstructive Surgery	
19307	nodes (Urban type operation) Mastectomy, modified radical, including axillary lymph nodes, with or without pectoralis	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1027 Breast Reconstructive Surgery	
19316	minor muscle, but excluding pectoralis major muscle Mastopexy	Prior authorization is required and medical necessity criteria must be met. Cosmetic procedures	HHO-DE-MP-1216 Gender Affirmation Services and HHO-DE-	
19318		are a non-covered service. Reference policies for additional information. Prior authorization is required and medical necessity criteria must be met. Reference policies for	MP-1257 Bioengineered Skin and Skin Replacement Therapy HHO-DE-MP-1027 Breast Reconstructive Surgery	
19318	Breast reduction	additional information.		
19325	Breast augmentation with implant	Prior authorization is required and medical necessity criteria must be met. Cosmetic procedures are a non-covered service. Reference policies for additional information.	HHO-DE-MP-1027 Breast Reconstructive Surgery and HHO-DE- MP-1216 Gender Affirmation Services	
19328	Removal of intact breast implant	Prior authorization is required and medical necessity criteria must be met. Reference policies for additional information.	HHO-DE-MP-1027 Breast Reconstructive Surgery	
19330	Removal of ruptured breast implant, including implant contents (eg, saline, silicone gel)	Prior authorization is required and medical necessity criteria must be met. Reference policies for additional information.	HHO-DE-MP-1027 Breast Reconstructive Surgery	
19340	Insertion of breast implant on same day of mastectomy (ie, immediate)	Prior authorization is required and medical necessity criteria must be met. Cosmetic procedures are a non-covered service. Reference policies for additional information.	HHO-DE-MP-1027 Breast Reconstructive Surgery and HHO-DE- MP-1216 Gender Affirmation Services	
19342	Insertion or replacement of breast implant on separate day from mastectomy	Prior authorization is required and medical necessity criteria must be met. Cosmetic procedures are a non-covered service. Reference policies for additional information.	HHO-DE-MP-1027 Breast Reconstructive Surgery and HHO-DE- MP-1216 Gender Affirmation Services	
19350	Nipple/areola reconstruction	Prior authorization is required and medical necessity criteria must be met. Cosmetic procedures are a non-covered service. Reference policies for additional information.	HHO-DE-MP-1027 Breast Reconstructive Surgery and HHO-DE- MP-1216 Gender Affirmation Services	
19355	Correction of inverted nipples	Prior authorization is required and medical necessity criteria must be met. Cosmetic procedures are a non-covered service.	W-1210 Gender Ammadon Services	
19357	Tissue expander placement in breast reconstruction, including subsequent expansion(s)	Prior authorization is required and medical necessity criteria must be met. Cosmetic procedures	HHO-DE-MP-1027 Breast Reconstructive Surgery and HHO-DE-	
19361	Breast reconstruction; with latissimus dorsi flap	are a non-covered service. Reference policies for additional information. Prior authorization is required and medical necessity criteria must be met. Cosmetic procedures	MP-1216 Gender Affirmation Services HHO-DE-MP-1027 Breast Reconstructive Surgery and HHO-DE-	
19364	Breast reconstruction; with free flap (eg, fTRAM, DIEP, SIEA, GAP flap)	are a non-covered service. Reference policies for additional information. Prior authorization is required and medical necessity criteria must be met. Cosmetic procedures	MP-1216 Gender Affirmation Services HHO-DE-MP-1027 Breast Reconstructive Surgery and HHO-DE-	
15504		are a non-covered service. Reference policies for additional information.	MP-1216 Gender Affirmation Services	
19367	Breast reconstruction; with single-pedicled transverse rectus abdominis myocutaneous (TRAM) flap	Prior authorization is required and medical necessity criteria must be met. Cosmetic procedures are a non-covered service. Reference policies for additional information.	HHO-DE-MP-1027 Breast Reconstructive Surgery	
19368	Breast reconstruction; with single-pedicled transverse rectus abdominis myocutaneous	Prior authorization is required and medical necessity criteria must be met. Cosmetic procedures	HHO-DE-MP-1027 Breast Reconstructive Surgery and HHO-DE-	
19369	(TRAM) flap, requiring separate microvascular anastomosis (supercharging) Breast reconstruction; with bipedicled transverse rectus abdominis myocutaneous (TRAM)	are a non-covered service. Reference policies for additional information. Prior authorization is required and medical necessity criteria must be met. Cosmetic procedures	MP-1216 Gender Affirmation Services HHO-DE-MP-1027 Breast Reconstructive Surgery and HHO-DE-	
19370	flap Revision of peri-implant capsule, breast, including capsulotomy, capsulorrhaphy and/or	are a non-covered service. Reference policies for additional information. Prior authorization is required and medical necessity criteria must be met.	MP-1216 Gender Affirmation Services	
15570	partial capsulectomy	Cosmetic procedures are a non-covered service.		
19371	Peri-implant capsulectomy, breast, complete, including removal of all intracapsular contents	Prior authorization is required and medical necessity criteria must be met. Cosmetic procedures are a non-covered service.		
19380	Revision of reconstructed breast (eg., significant removal of tissue, re-advancement and/or re-inset of flaps in autologous reconstruction or significant capsular revision combined with soft tissue excision in implant-based reconstruction)	Prior authorization is required and medical necessity criteria must be met. Cosmetic procedures are a non-covered service. Reference policies for additional information.	HHO-DE-MP-1216 Gender Affirmation Services and HHO-DE- MP-1257 Bioengineered Skin and Skin Replacement Therapy	
19396	Preparation of moulage for custom breast implant	Prior authorization is required and medical necessity criteria must be met. Cosmetic procedures are a non-covered service. Reference policies for additional information.	HHO-DE-MP-1027 Breast Reconstructive Surgery	
19499	Unlisted procedure, breast	Prior authorization is required for not otherwise classified codes and medical necessity criteria must be met. Cosmetic procedures are a non-covered service. Reference policies for additional information.	HHO-DE-MP-1027 Breast Reconstructive Surgery	
20550	Injection(s); single tendon sheath, or ligament, aponeurosis (e.g., plantar "fascia"	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1253 Ultrasound Guidance for Joint, Tendon, Tendon Sheath and Trigger Point Injections	
20604	Arthrocentesis, aspiration and/or injection, small joint or bursa (e.g., fingers, toes); with ultrasound guidance, with permanent recording and reporting	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1253 Ultrasound Guidance for Joint, Tendon, Tendon Sheath and Trigger Point Injections	
	Arthrocentesis, aspiration and/or injection; intermediate joint or bursa (e.g.,			
20606	temporomandibular, acromioclavicular, wrist, elbow or ankle, olecranon bursa); with ultrasound guidance, with permanent recording and reporting	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1253 Ultrasound Guidance for Joint, Tendon, Tendon Sheath and Trigger Point Injections	
20611	Arthrocentesis, aspiration and/or injection; major joint or bursa (e.g., shoulder, hip, knee joint, subacromial bursa); with ultrasound guidance, with permanent recording and reportine	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1253 Ultrasound Guidance for Joint, Tendon, Tendon Sheath and Trigger Point Injections	
20930	Allograft, morselized, or placement of osteopromotive material, for spine surgery only (List separately in addition to code for primary procedure)	Prior authorization is managed by EviCore.		Prior authorization is managed I EviCore.
20931	separately in addition to code for primary procedure) Allograft, structural, for spine surgery only (List separately in addition to code for primary procedure)	Prior authorization is managed by EviCore.		Prior authorization is managed I EviCore.
20932	Allograft, includes templating, cutting, placement and internal fixation, when performed; osteoarticular, including articular surface and contiguous bone (List separately in addition to code for primary procedure)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1122 Orthopedic Applications of Stem-Cell Therapy	circore.

20933	Allograft, includes templating, cutting, placement and internal fixation, when performed; hemicortical intercalary, partial (ie, hemicylindrical) (List separately in addition to code for primary procedure)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1122 Orthopedic Applications of Stem-Cell Therapy	
20934	Allograft, includes templating, cutting, placement and internal fixation, when performed; intercalary, complete (ie, cylindrical) (List separately in addition to code for primary procedure)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1122 Orthopedic Applications of Stem-Cell Therapy	
20936	Autograft for spine surgery only (includes harvesting the graft); local (e.g., ribs, spinous process, or laminar fragments) obtained from same incision (List separately in addition to code for primary procedure)	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
20937	Autograft for spine surgery only (includes harvesting the graft); morselized (through separate skin or fascial incision) (List separately in addition to code for primary procedure)	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
20938	Autograft for spine surgery only (includes harvesting the graft); structural, bicortical or tricortical (through separate skin or fascial incision) (List separately in addition to code for primary procedure)	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
20974	Electrical stimulation to aid bone healing; noninvasive (nonoperative)	Prior authorization is managed by EviCore. Reference policies for additional information.	HHO-DE-MP-1148 Electrical Bone Growth Stimulation Spinal and HHO-DE-MP-1149 Non-Spinal Bone Growth Stimulation	Prior authorization is managed by EviCore.
20975	Electrical stimulation to aid bone healing; invasive (operative)	Prior authorization is managed by EviCore. Reference policies for additional information.	HHO-DE-MP-1148 Electrical Bone Growth Stimulation Spinal and HHO-DE-MP-1149 Non-Spinal Bone Growth Stimulation	Prior authorization is managed by EviCore.
20979	Low intensity ultrasound stimulation to aid bone healing, noninvasive (nonoperative)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1251 Ultrasound Osteogenesis Stimulator	
20982	Ablation therapy for reduction or eradication of 1 or more bone tumors (eg, metastasis) including adjacent soft tissue when involved by tumor extension, percutaneous, including	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1218 Radiofrequency Ablation of Miscellaneous Solid Tumors	
20983	imaging guidance when performed; radiofrequency Ablation therapy for reduction or eradication of 1 or more bone tumors (eg, metastasis) including adjacent soft tissue when involved by tumor extension, percutaneous, including imaging guidance when performed; cryoablation	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1218 Radiofrequency Ablation of Miscellaneous Solid Tumors	
20999	Unlisted procedure, musculoskeletal system, general	Prior authorization is required.		
21010	Arthrotomy, temporomandibular joint	Prior authorization is required.	1	1
21050	Condylectomy, temporomandibular joint (separate procedure)	Prior authorization is required.		
21060	Meniscectomy, partial or complete, temporomandibular joint (separate procedure)	Prior authorization is required.		
21070	Coronoidectomy (separate procedure)	Prior authorization is required.		
21073	Manipulation of temporomandibular joint(s) (TMJ), therapeutic, requiring an anesthesia	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1136 Temporomandibular Joint Dysfunction	
21089	service (ie, general or monitored anesthesia care) Unlisted maxillofacial prosthetic procedure	Prior authorization is required.		
21085	Injection procedure for temporomandibular joint arthrography	Prior authorization is required.		
	Genioplasty; sliding osteotomies, 2 or more osteotomies (eg, wedge excision or bone	The automation stephica.	HHO-DE-MP-1064 Diagnosis and Treatment of Obstructive	
21122	wedge reversal for asymmetrical chin)	Prior authorization is required. Reference policies for additional information.	Sleep Apnea in Adults	
21123	Genioplasty; sliding, augmentation with interpositional bone grafts (includes obtaining autografts)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1064 Diagnosis and Treatment of Obstructive Sleep Apnea in Adults	
21195	Reconstruction of mandibular rami and/or body, sagittal split; without internal rigid fixation	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1064 Diagnosis and Treatment of Obstructive Sleep Apnea in Adults	
21196	Reconstruction of mandibular rami and/or body, sagittal split; with internal rigid fixation	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1064 Diagnosis and Treatment of Obstructive Sleep Apnea in Adults	
21199	Osteotomy, mandible, segmental; with genioglossus advancement	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1064 Diagnosis and Treatment of Obstructive Sleep Apnea in Adults	
21240	Arthroplasty, temporomandibular joint, with or without autograft (includes obtaining graft)	Prior authorization is required.		
21242	Arthroplasty, temporomandibular joint, with allograft	Prior authorization is required.		
21299	Unlisted craniofacial and maxillofacial procedure	Prior authorization is required.		
21480	Closed treatment of temporomandibular dislocation; initial or subsequent	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1136 Temporomandibular Joint Dysfunction	
21485	Closed treatment of temporomandibular dislocation; complicated (eg, recurrent requiring intermaxillary fixation or splinting), initial or subsequent	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1136 Temporomandibular Joint Dysfunction	
21490	Open treatment of temporomandibular dislocation	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1136 Temporomandibular Joint Dysfunction	
21499	Musculoskeletal procedure: Head	Prior authorization is required.		
21685	Hyoid myotomy and suspension	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1064 Diagnosis and Treatment of Obstructive Sleep Apnea in Adults	
21012	Open treatment of rib fracture(s) with internal fixation, includes thoracoscopic visualization	Drive outboright isis		
21812	when performed, unilateral; 4-6 ribs	Prior authorization is required.		
21899	Procedure: Neck or thorax	Prior authorization is required.		
22214	Osteotomy of spine, posterior or posterolateral approach, 1 vertebral segment; lumbar	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
22510	Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection, inclusive of all imaging guidance; cervicothoracic	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
22511	Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection, inclusive of all imaging guidance; lumbosacral	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
22512	Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection, inclusive of all imaging guidance; each additional cervicothoracic or lumbosacral vertebral body (List separately in addition to code for primary procedure)	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
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22513	Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device (e.g., kyphoplasty), 1 vertebral body, unilateral or bilateral cannulation, inclusive of all imaging guidance; thoracic	Prior authorization is managed by EviCore.	Prior authorization is managed by EviCore.
22514	Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device (e.g., kyphoplasty), 1 vertebral body, unilateral or bilateral cannulation, inclusive of all imaging guidance; lumbar	Prior authorization is managed by EviCore.	Prior authorization is managed by EviCore.
22515	Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed)	Prior authorization is managed by EviCore.	Prior authorization is managed by EviCore.
22526	Percutaneous intradiscal electrothermal annuloplasty, unilateral or bilateral including fluoroscopic guidance; single level	Prior authorization is managed by EviCore.	Prior authorization is managed by EviCore.
22527	Percutaneous intradiscal electrothermal annuloplasty, unilateral or bilateral including fluoroscopic guidance; 1 or more additional levels (List separately in addition to code for primary procedure)	Prior authorization is managed by EviCore.	Prior authorization is managed by EviCore.
22532	Lateral Extracavitary Approach Technique ArthrodesisProcedures on the Spine (Vertebral Column).	Prior authorization is managed by EviCore.	Prior authorization is managed by EviCore.
22533	Arthrodesis, lateral extracavitary technique, including minimal discectomy to prepare interspace (other than for decompression); lumbar	Prior authorization is managed by EviCore.	Prior authorization is managed by EviCore.
22534	Arthrodesis, lateral extracavitary technique, including minimal discectomy to prepare interspace (other than for decompression); thoracic or lumbar, each additional vertebral segment (List separately in addition to code for primary procedure)	Prior authorization is managed by EviCore.	Prior authorization is managed by EviCore.
22551	Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophytectomy and decompression of spinal cord and/or nerve roots; cervical below C2	Prior authorization is managed by EviCore.	Prior authorization is managed by EviCore.
22552	Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophytectomy and decompression of spinal cord and/or nerve roots; cervical below C2, each additional interspace (List separately in addition to code for separate procedure)	Prior authorization is managed by EviCore.	Prior authorization is managed by EviCore.
22554	Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); cervical below C2	Prior authorization is managed by EviCore.	Prior authorization is managed by EviCore.
22558	Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); lumbar	Prior authorization is managed by EviCore.	Prior authorization is managed by EviCore.
22585	Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); each additional interspace (List separately in addition to code for primary procedure)	Prior authorization is managed by EviCore.	Prior authorization is managed by EviCore.
22586	Arthrodesis, pre-sacral interbody technique, including disc space preparation, discectomy, with posterior instrumentation, with image guidance, includes bone graft when performed, L5-S1 interspace	Prior authorization is managed by EviCore.	Prior authorization is managed by EviCore.
22595	Arthrodesis, posterior technique, atlas-axis (C1-C2)	Prior authorization is managed by EviCore.	Prior authorization is managed by EviCore.
22600	Arthrodesis, posterior or posterolateral technique, single interspace; cervical below C2 segment	Prior authorization is managed by EviCore.	Prior authorization is managed by EviCore.
22612	Arthrodesis, posterior or posterolateral technique, single interspace; lumbar (with lateral transverse technique, when performed)	Prior authorization is managed by EviCore.	Prior authorization is managed by EviCore.
22614	Arthrodesis, posterior or posterolateral technique, single interspace; each additional interspace (List separately in addition to code for primary procedure)	Prior authorization is managed by EviCore.	Prior authorization is managed by EviCore.
22630	Arthrodesis, posterior interbody technique, including laminectomy and/or discectomy to prepare interspace (other than for decompression), single interspace; lumbar	Prior authorization is managed by EviCore.	Prior authorization is managed by EviCore.
22632	Arthrodesis, posterior interbody technique, including laminectomy and/or discectomy to prepare interspace (other than for decompression), single interspace; each additional interspace (List separately in addition to code for primary procedure)	Prior authorization is managed by EviCore.	Prior authorization is managed by EviCore.
22633	Arthrodesis, combined posterior or posterolateral technique with posterior interbody technique including laminectomy and/or discectomy sufficient to prepare interspace (other than for decompression), single interspace; lumbar	Prior authorization is managed by EviCore.	Prior authorization is managed by EviCore.
22634	Arthrodesis, combined posterior or posterolateral technique with posterior interbody technique including laminectomy and/or discectomy sufficient to prepare interspace (other than for decompression), single interspace; each additional interspace and segment (List separately in addition to code for primary procedure)	Prior authorization is managed by EviCore.	Prior authorization is managed by EviCore.
22830	Exploration of spinal fusion	Prior authorization is managed by EviCore.	Prior authorization is managed by EviCore.
22836	Anterior thoracic vertebral body tethering, including thoracoscopy, when performed; up to		EVICUIE.
22837	7 vertebral segments Anterior thoracic vertebral body tethering, including thoracoscopy, when performed; 8 or more vertebral segments		
22838	Arthrodesis, sacroiliac joint, percutaneous, with image guidance, including placement of intra-articular implant(s) (eg, bone allograft(s), synthetic device[s]), without placement of transfixation device		
22840	Posterior non-segmental instrumentation (eg, Harrington rod technique, pedicle fixation across 1 interspace, atlantoaxial transarticular screw fixation, sublaminar wiring at C1, facet screw fixation) (List separately in addition to code for primary procedure)	Prior authorization is managed by EviCore.	Prior authorization is managed by EviCore.

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22841	Internal spinal fixation by wiring of spinous processes (List separately in addition to code for primary procedure)	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
22842	Posterior segmental instrumentation (e.g., pedicle fixation, dual rods with multiple hooks and sublaminar wires); 3 to 6 vertebral segments (List separately in addition to code for primary procedure)	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
22843	Posterior segmental instrumentation (e.g., pedicle fixation, dual rods with multiple hooks and sublaminar wires); 7 to 12 vertebral segments (List separately in addition to code for primary procedure)	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
22844	Posterior segmental instrumentation (e.g., pedicle fixation, dual rods with multiple hooks and sublaminar wires); 13 or more vertebral segments (List separately in addition to code for primary procedure)	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
22845	Anterior instrumentation; 2 to 3 vertebral segments (List separately in addition to code for primary procedure)	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
22846	Anterior instrumentation; 4 to 7 vertebral segments (List separately in addition to code for primary procedure)	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
22847	Anterior instrumentation; 8 or more vertebral segments (List separately in addition to code for primary procedure)	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
22848	Pelvic fixation (attachment of caudal end of instrumentation to pelvic bony structures) other than sacrum (List separately in addition to code for primary procedure)	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
22852	Removal of posterior segmental instrumentation	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
22853	Insertion of interbody biomechanical device(s) (e.g., synthetic cage, mesh) with integral anterior instrumentation for device anchoring (e.g., screws, flanges), when performed, to intervertebral disc space in conjunction with interbody arthrodesis, each interspace (List separately in addition to code for primary procedure	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
22854	Insertion of intervertebral biomechanical device(s) (e.g., synthetic cage, mesh) with integral anterior instrumentation for device anchoring (e.g., screws, flanges), when performed, to vertebral corpectomy(ies) (vertebral body resection, partial or complete) defect, in conjunction with interbody arthrodesis, each contiguous defect (List separately in addition to code for primary procedure)	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
22855	Removal of anterior instrumentation	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
22856	Total disc arthroplasty (artificial disc), anterior approach, including discectomy with end plate preparation (includes osteophytectomy for nerve root or spinal cord decompression and microdissection); single interspace, cervical	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
22857	Total disc arthroplasty (artificial disc), anterior approach, including discectomy to prepare interspace (other than for decompression), single interspace, lumbar	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
22858	Total disc arthroplasty (artificial disc), anterior approach, including discectomy with end plate preparation (includes osteophytectomy for nerve root or spinal cord decompression and microdissection); second level, cervical (List separately in addition to code for primary procedure)	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
22859	Insertion of intervertebral biomechanical device(s) (e.g., synthetic cage, mesh, methylmethacrylate) to intervertebral disc space or vertebral body defect without interbody arthrodesis, each contiguous defect (List separately in addition to code for primary procedure)	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
22860	Total disc arthroplasty (artificial disc), anterior approach, including discectomy to prepare interspace (other than for decompression); second interspace, lumbar (List separately in addition to code for primary procedure)	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
22861	Revision including replacement of total disc arthroplasty (artificial disc), anterior approach, single interspace; cervical	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
22862	Revision including replacement of total disc arthroplasty (artificial disc), anterior approach, single interspace; lumbar	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
22867	Insertion of interlaminar/interspinous process stabilization/distraction device, without fusion, including image guidance when performed, with open decompression, lumbar; single level	Prior authorization is required and managed by EviCore. Reference policies for additional information.	HHO-DE-MP-1155 Interspinous and Interlaminar Stabilization/Distraction Devices	Prior authorization is managed by EviCore.
22868	Insertion of interlaminar/interspinous process stabilization/distraction device, without fusion, including image guidance when performed, with open decompression, lumbar; second level (List separately in addition to code for primary procedure)	Prior authorization is required and managed by EviCore. Reference policies for additional information.	HHO-DE-MP-1155 Interspinous and Interlaminar Stabilization/Distraction Devices	Prior authorization is managed by EviCore.
22869	Insertion of interlaminar/interspinous process stabilization/distraction device, without open decompression or fusion, including image guidance when performed, lumbar; single level	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1155 Interspinous and Interlaminar Stabilization/Distraction Devices	
22870	Insertion of interlaminar/interspinous process stabilization/distraction device, without open decompression or fusion, including image guidance when performed, lumbar; second level (List separately in addition to code for primary procedure)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1155 Interspinous and Interlaminar Stabilization/Distraction Devices	
22899	Unlisted procedure, spine	Prior authorization is required for not otherwise classified codes. Reference policies for additional information.	HHO-DE-MP-1155 Interspinous and Interlaminar Stabilization/Distraction Devices	
23000	Removal of subdeltoid calcareous deposits, open	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
23020	Capsular contracture release (e.g., Sever type procedure)	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
23120	Claviculectomy; partial	Prior authorization is managed by EviCore.		Prior authorization is managed by

23130	Acromioplasty or acromionectomy, partial, with or without coracoacromial ligament release	Prior authorization is managed by EviCore.	Prior authorization is managed by EviCore.
23410	Repair of ruptured musculotendinous cuff (e.g., rotator cuff) open; acute	Prior authorization is managed by EviCore.	Prior authorization is managed by EviCore.
23412	Repair of ruptured musculotendinous cuff (e.g., rotator cuff) open; chronic	Prior authorization is managed by EviCore.	Prior authorization is managed by EviCore.
23415	Coracoacromial ligament release, with or without acromioplasty	Prior authorization is managed by EviCore.	Prior authorization is managed by EviCore.
23420	Reconstruction of complete shoulder (rotator) cuff avulsion, chronic (includes acromioplasty)	Prior authorization is managed by EviCore.	Prior authorization is managed by EviCore.
23430	Tenodesis of long tendon of biceps	Prior authorization is managed by EviCore.	Prior authorization is managed by EviCore.
23440	Resection or transplantation of long tendon of biceps	Prior authorization is managed by EviCore.	Prior authorization is managed by
23450	Capsulorrhaphy, anterior, Putti-Platt procedure or Magnuson type operation	Prior authorization is managed by EviCore.	EviCore. Prior authorization is managed by
23455	Capsulorrhaphy, anterior; with labral repair (e.g., Bankart procedure)	Prior authorization is managed by EviCore.	EviCore. Prior authorization is managed by
23460	Capsulormaphy, anterior, any type; with bone block	Prior authorization is managed by EviCore.	EviCore. Prior authorization is managed by
23462	Capsulorrhaphy, anterior, any type; with coracoid process transfer	Prior authorization is managed by EviCore.	EviCore. Prior authorization is managed by
			EviCore. Prior authorization is managed by
23465	Capsulorrhaphy, glenohumeral joint, posterior, with or without bone block	Prior authorization is managed by EviCore.	EviCore. Prior authorization is managed by
23466	Capsulorrhaphy, glenohumeral joint, any type multi-directional instability	Prior authorization is managed by EviCore.	EviCore. Prior authorization is managed by
23470	Arthroplasty, glenohumeral joint; hemiarthroplasty Arthroplasty, glenohumeral joint; total shoulder (glenoid and proximal humeral	Prior authorization is managed by EviCore.	EviCore. Prior authorization is managed by
23472	replacement (e.g., total shoulder))	Prior authorization is managed by EviCore.	EviCore.
23473	Revision of total shoulder arthroplasty, including allograft when performed; humeral or glenoid component	Prior authorization is managed by EviCore.	Prior authorization is managed by EviCore.
23474	Revision of total shoulder arthroplasty, including allograft when performed; humeral and glenoid component	Prior authorization is managed by EviCore.	Prior authorization is managed by EviCore.
23929	Unlisted procedure, shoulder	Prior authorization is required.	
24999	Unlisted procedure, humerus or elbow	Prior authorization is required.	
25999	Unlisted procedure, forearm or wrist	Prior authorization is required.	
26989	Unlisted procedure, hands or fingers	Prior authorization is required.	
27096	Injection procedure for sacroiliac joint, anesthetic/steroid, with image guidance (fluoroscopy or CT) including arthrography when performed	Prior authorization is managed by EviCore.	Prior authorization is managed by EviCore.
27125	Hemiarthroplasty, hip, partial (e.g., femoral stem prosthesis, bipolar arthroplasty)	Prior authorization is managed by EviCore.	Prior authorization is managed by EviCore.
27130	Arthroplasty, acetabular and proximal femoral prosthetic replacement (total hip arthroplasty), with or without autograft or allograft	Prior authorization is managed by EviCore.	Prior authorization is managed by EviCore.
27132	Conversion of previous hip surgery to total hip arthroplasty, with or without autograft or allograft	Prior authorization is managed by EviCore.	Prior authorization is managed by EviCore.
27134	Revision of total hip arthroplasty; both components, with or without autograft or allograft	Prior authorization is managed by EviCore.	Prior authorization is managed by EViCore.
27137	Revision of total hip arthroplasty; acetabular component only, with or without autograft or	Prior authorization is managed by EviCore.	Prior authorization is managed by
27138	allograft Revision of total hip arthroplasty; femoral component only, with or without allograft	Prior authorization is managed by EviCore.	EviCore. Prior authorization is managed by
27278	Arthrodesis, sacroiliac joint, percutaneous, with image guidance, includes placement of	Prior authorization is managed by EviCore.	EviCore. Prior authorization is managed by
27270	intra-articular implant(s) Arthrodesis, sacroiliac joint, percutaneous or minimally invasive (indirect visualization), with		EviCore. Prior authorization is managed by
27279	image guidance, includes obtaining bone graft when performed and placement of transfixing device	Prior authorization is managed by EviCore.	EviCore.
27280	Arthrodesis, open, sacroiliac joint, including obtaining bone graft, including instrumentation, when performed	Prior authorization is managed by EviCore.	Prior authorization is managed by
27200			EviCore.
27299 27332	Unlisted procedure, pelvis or hip joint Arthrotomy, with excision of semilunar cartilage (meniscectomy) knee; medial OR lateral	Prior authorization is required. Prior authorization is managed by EviCore.	Prior authorization is managed by
27333	Arthrotomy, with excision of semilunar cartilage (meniscectomy) knee; medial AND lateral	Prior authorization is managed by EviCore.	EviCore. Prior authorization is managed by
27334	Arthrotomy, with synovectomy, knee; anterior OR posterior	Prior authorization is managed by EviCore.	EviCore. Prior authorization is managed by
27335	Arthrotomy, with synovectomy, knee; anterior AND posterior including popliteal area	Prior authorization is managed by EviCore.	EviCore. Prior authorization is managed by
27333	Arthrotomy, with synovectomy, knee, anterior AND posterior including popiliear area Arthrotomy with meniscus repair, knee	Prior authorization is managed by EviCore.	EviCore. Prior authorization is managed by
			EviCore.

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

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

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

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

	Endoscopy, surgical; operative tissue ablation and reconstruction of atria, limited (eg,			
33265	modified maze procedure), without cardiopulmonary bypass	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1187 Cardiac Ablation Procedure	
33266	Endoscopy, surgical; operative tissue ablation and reconstruction of atria, extensive (eg, maze procedure), without cardiopulmonary bypass	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1187 Cardiac Ablation Procedure	
33270	Insertion or replacement of permanent subcutaneous implantable defibrillator system, with subcutaneous electrode, including defibrillator threshold evaluation, induction of arrhythmia, evaluation of sensing for arrhythmia termination, and programming or reprogramming of sensing or therapeutic parameters, when performed	Prior authorization is required.		
33274	Transcatheter insertion or replacement of permanent leadless pacemaker, right ventricular, including imaging guidance (eg, fluoroscopy, venous ultrasound, ventriculography, femoral venography) and device evaluation (eg, interrogation or programming), when performed	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
33275	Transcatheter removal of permanent leadless pacemaker, right ventricular	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
33289	Transcatheter implantation of wireless pulmonary artery pressure sensor for long-term hemodynamic monitoring, including deployment and calibration of the sensor, right heart catheterization, selective pulmonary catheterization, radiological supervision and interpretation and pulmonary artery angiography, when performed	Prior authorization is managed by EviCore. Reference policies for additional information.		Prior authorization is managed by EviCore.
33340	Percutaneous transcatheter closure of the left atrial appendage with endocardial implant, including fluoroscopy, transseptal puncture, catheter placement(s), left atrial angiography, left atrial appendage angiography, when performed and radiological supervision and interpretation	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1151 Percutaneous Left Atrial Appendage Closure (LAAC) Device	
33361	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; percutaneous femoral artery approach	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1125 Transcatheter Aortic Valve Replacement	
33362	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; open femoral artery approach	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1125 Transcatheter Aortic Valve Replacement	
33363	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; open axillary artery approach	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1125 Transcatheter Aortic Valve Replacement	
33364	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; open iliac artery approach	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1125 Transcatheter Aortic Valve Replacement	
33365	Transcatheter a ortic valve replacement (TAVR/TAVI) with prosthetic valve; transaortic approach (eg, median sternotomy, mediastinotomy)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1125 Transcatheter Aortic Valve Replacement	
33366	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; transapical exposure (eg, left thoracotomy)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1125 Transcatheter Aortic Valve Replacement	
33367	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; cardiopulmonary bypass support with percutaneous peripheral arterial and venous cannulation (eg, femoral vessels) (List separately in addition to code for primary procedure)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1125 Transcatheter Aortic Valve Replacement	
33368	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; cardiopulmonary bypass support with open peripheral arterial and venous cannulation (eg, femoral, iliac, axillary vessels) (List separately in addition to code for primary procedure)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1125 Transcatheter Aortic Valve Replacement	
33369	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; cardiopulmonary bypass support with central arterial and venous cannulation (eg, aorta, right atrium, pulmonary artery) (List separately in addition to code for primary procedure)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1125 Transcatheter Aortic Valve Replacement	
33370	Transcatheter placement and subsequent removal of cerebral embolic protection device(s), including arterial access, catheterization, imaging and radiological supervision and interpretation, percutaneous (List separately in addition to code for primary procedure)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1125 Transcatheter Aortic Valve Replacement	
33418	Transcatheter mitral valve repair, percutaneous approach, including transseptal puncture when performed; initial prosthesis	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1126 Transcatheter Mitral Valve Repair/Replacement	
33419	Transcatheter mitral valve repair, percutaneous approach, including transseptal puncture when performed; additional prosthesis(es) during same session (List separately in addition to code for primary procedure)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1126 Transcatheter Mitral Valve Repair/Replacement	
33477	Transcatheter pulmonary valve implantation, percutaneous approach, including pre- stenting of the valve delivery site, when performed	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1022 Transcatheter Pulmonary Valve Implantation	
33880	Endovascular repair of descending thoracic aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption); involving coverage of left subclavian artery origin, initial endoprosthesis plus descending thoracic aortic extension(s), if required, to level of celiac artery origin	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1157 Endovascular/Endoluminal Stent Grafts	
33881	Endovascular repair of descending thoracic aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption); not involving coverage of left subclavian artery origin, initial endoprosthesis plus descending thoracic aortic extension(5), if required, to level of celiac artery origin	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1157 Endovascular/Endoluminal Stent Grafts	
33883	Placement of proximal extension prosthesis for endovascular repair of descending thoracic aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption); initial extension	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1157 Endovascular/Endoluminal Stent Grafts	
33884	Placement of proximal extension prosthesis for endovascular repair of descending thoracic aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption); each additional proximal extension (List separately in addition to code for primary procedure)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1157 Endovascular/Endoluminal Stent Grafts	

	Discoment of distal outposing prosthesis(a) delayed after and an angle and the			
33886	Placement of distal extension prosthesis(s) delayed after endovascular repair of descending thoracic aorta	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1157 Endovascular/Endoluminal Stent Grafts	
33889	Open subclavian to carotid artery transposition performed in conjunction with endovascular repair of descending thoracic aorta, by neck incision, unilateral	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1157 Endovascular/Endoluminal Stent Grafts	
33891	Bypass graft, with other than vein, transcervical retropharyngeal carotid-carotid, performed in conjunction with endovascular repair of descending thoracic aorta, by neck incision	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1157 Endovascular/Endoluminal Stent Grafts	
33927	Implantation of a total replacement heart system (artificial heart) with recipient cardiectomy	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1104 Artificial Hearts and Ventricular Assist Devices	
33928	Removal and replacement of total replacement heart system (artificial heart)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1104 Artificial Hearts and Ventricular Assist Devices	
33929	Removal of a total replacement heart system (artificial heart) for heart transplantation (List separately in addition to code for primary procedure)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1104 Artificial Hearts and Ventricular Assist Devices	
33935	Heart-lung transplant with recipient cardiectomy-pneumonectomy	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1108 Heart/Lung Transplant	
33945	Backbench standard preparation of cadaver donor heart allograft prior to transplantation, including dissection of allograft from surrounding soft tissues to prepare aorta, superior vena cava, inferior vena cava, pulmonary artery and left atrium for implantation	Prior authorization is required.		
33946	Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; initiation, veno-venous	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1061 Extracorporeal Membrane Oxygenation (ECMO)	
33947	Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; initiation, veno-arterial	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1061 Extracorporeal Membrane Oxygenation (ECMO)	
33948	Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; daily management, each day, veno-venous	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1061 Extracorporeal Membrane Oxygenation (ECMO)	
33949	Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; daily management, each day, veno-arterial	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1061 Extracorporeal Membrane Oxygenation (ECMO)	
33951	Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; insertion of peripheral (arterial and/or venous) cannula(e), percutaneous, birth through 5 years of age (includes fluoroscopic guidance, when performed)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1061 Extracorporeal Membrane Oxygenation (ECMO)	
33953	Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; insertion of peripheral (arterial and/or venous) cannula(e), open, birth through 5 years of age	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1061 Extracorporeal Membrane Oxygenation (ECMO)	
33954	Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; insertion of peripheral (arterial and/or venous) cannula(e), open, 6 years and older	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1061 Extracorporeal Membrane Oxygenation (ECMO)	
33955	Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; insertion of central cannula(e) by sternotomy or thoracotomy, birth through 5 years of age	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1061 Extracorporeal Membrane Oxygenation (ECMO)	
33956	Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; insertion of central cannula(e) by sternotomy or thoracotomy, 6 years and older	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1061 Extracorporeal Membrane Oxygenation (ECMO)	
33957	Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; reposition peripheral (arterial and/or venous) cannula(e), percutaneous, birth through 5 years of age (includes fluoroscopic guidance, when performed)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1061 Extracorporeal Membrane Oxygenation (ECMO)	
33958	Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; reposition peripheral (arterial and/or venous) cannula(e), percutaneous, 6 years and older (includes fluoroscopic guidance, when performed)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1061 Extracorporeal Membrane Oxygenation (ECMO)	
33959	Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; reposition peripheral (arterial and/or venous) cannula(e), open, birth through 5 years of age (includes fluoroscopic guidance, when performed)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1061 Extracorporeal Membrane Oxygenation (ECMO)	
33962	Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; reposition peripheral (arterial and/or venous) cannula(e), open, 6 years and older (includes fluoroscopic guidance, when performed)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1061 Extracorporeal Membrane Oxygenation (ECMO)	
33963	Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; reposition of central cannula(e) by stemotomy or thoracotomy, birth through 5 years of age (includes fluoroscopic guidance, when performed)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1061 Extracorporeal Membrane Oxygenation (ECMO)	
33964	Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; reposition central cannula(e) by sternotomy or thoracotomy, 6 years and older (includes fluoroscopic guidance, when performed)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1061 Extracorporeal Membrane Oxygenation (ECMO)	
33965	Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; removal of peripheral (arterial and/or venous) cannula(e), percutaneous, birth through 5 years of age	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1061 Extracorporeal Membrane Oxygenation (ECMO)	
33966	Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; removal of peripheral (arterial and/or venous) cannula(e), percutaneous, 6 years and older	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1061 Extracorporeal Membrane Oxygenation (ECMO)	
33969	Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; removal of peripheral (arterial and/or venous) cannula(e), open, birth through 5 years of age	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1061 Extracorporeal Membrane Oxygenation (ECMO)	
33975	Insertion of ventricular assist device; extracorporeal, single ventricle	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1104 Artificial Hearts and Ventricular Assist Devices	

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33976	Insertion of ventricular assist device; extracorporeal, biventricular	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1104 Artificial Hearts and Ventricular Assist Devices	
33977	Removal of ventricular assist device; extracorporeal, single ventricle	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1104 Artificial Hearts and Ventricular Assist Devices	
33978	Removal of ventricular assist device; extracorporeal, biventricular	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1104 Artificial Hearts and Ventricular Assist Devices	
33979	Insertion of ventricular assist device, implantable intracorporeal, single ventricle	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1104 Artificial Hearts and Ventricular Assist Devices	
33980	Removal of ventricular assist device, implantable intracorporeal, single ventricle	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1104 Artificial Hearts and Ventricular Assist Devices	
33981	Replacement of extracorporeal ventricular assist device, single or biventricular, pump(s), single or each pump	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1104 Artificial Hearts and Ventricular Assist Devices	
33982	Replacement of ventricular assist device pump(s); implantable intracorporeal, single ventricle, without cardiopulmonary bypass	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1104 Artificial Hearts and Ventricular Assist Devices	
33983	Replacement of ventricular assist device pump(s); implantable intracorporeal, single ventricle, with cardiopulmonary bypass	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1104 Artificial Hearts and Ventricular Assist Devices	
33984	Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; removal of peripheral (arterial and/or venous) cannula(e), open, 6 years and older	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1061 Extracorporeal Membrane Oxygenation (ECMO)	
33985	Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; removal of central cannula(e) by sternotomy or thoracotomy, birth through 5 years of age	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1061 Extracorporeal Membrane Oxygenation (ECMO)	
33986	Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; removal of central cannula(e) by sternotomy or thoracotomy, 6 years and older	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1061 Extracorporeal Membrane Oxygenation (ECMO)	
33987	Arterial exposure with creation of graft conduit (eg, chimney graft) to facilitate arterial perfusion for ECMO/ECLS (List separately in addition to code for primary procedure)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1061 Extracorporeal Membrane Oxygenation (ECMO)	
33988	Insertion of left heart vent by thoracic incision (eg, sternotomy, thoracotomy) for ECMO/ECLS	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1061 Extracorporeal Membrane Oxygenation (ECMO)	
33989	Removal of left heart vent by thoracic incision (eg, sternotomy, thoracotomy) for ECMO/ECLS	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1061 Extracorporeal Membrane Oxygenation (ECMO)	
33990	Insertion of ventricular assist device, percutaneous, including radiological supervision and interpretation; left heart, arterial access only	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1104 Artificial Hearts and Ventricular Assist Devices	
33991	Insertion of ventricular assist device, percutaneous, including radiological supervision and interpretation; left heart, both arterial and venous access, with transseptal puncture	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1104 Artificial Hearts and Ventricular Assist Devices	
33992	Removal of percutaneous left heart ventricular assist device, arterial or arterial and venous cannula(s), at separate and distinct session from insertion	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1104 Artificial Hearts and Ventricular Assist Devices	
33993	Repositioning of percutaneous right or left heart ventricular assist device with imaging guidance at separate and distinct session from insertion	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1104 Artificial Hearts and Ventricular Assist Devices	
33995	Insertion of ventricular assist device, percutaneous, including radiological supervision and interpretation; right heart, venous access only	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1104 Artificial Hearts and Ventricular Assist Devices	
33997	Removal of percutaneous right heart ventricular assist device, venous cannula, at separate and distinct session from insertion	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1104 Artificial Hearts and Ventricular Assist Devices	
33999	Unlisted procedure, cardiac surgery	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1104 Artificial Hearts and Ventricular Assist Devices	
34706	Endovascular repair of infrarenal aorta and/or iliac artery(ies) by deployment of an aorta-bi iliac endograft including pre-procedure sizing and device selection, all nonselective catheterization(s), all associated radiological supervision and interpretation, all endograft extension(s) placed in the aorta from the level of the renal arteries to the iliac bifurcation and all angioplasty/stenting performed from the level of the renal arteries to the iliac bifurcation; for rupture including temporary aortic and/or iliac baltoon occlusion, when performed (eg, for aneurysm, pseudoaneurysm, dissection, penetrating ulcer, traumatic disruption)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1157 Endovascular/Endoluminal Stent Grafts	
34707	Endovascular repair of iliac artery by deployment of an ilio-iliac tube endograft including pre-procedure sizing and device selection, all nonselective catheterization(s), all associated radiological supervision and interpretation and all endograft extension(s) proximally to the aortic bifurcation and distally to the liac bifurcation and treatment zone angioplasty/stenting, when performed, unilateral; for other than rupture (eg, for aneurysm, pseudoaneurysm, dissection, arteriovenous malformation)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1157 Endovascular/Endoluminal Stent Grafts	
34708	Endovascular repair of iliac artery by deployment of an ilio-iliac tube endograft including pre-procedure sizing and device selection, all nonselective catheterization(s), all associated radiological supervision and interpretation and all endograft extension(s) proximally to the aotic bifurcation and distally to the iliac bifurcation and treatment zone angioplasty/stenting, when performed, unilateral; for rupture including temporary aortic and/or iliac balloon occlusion, when performed (eg, for aneurysm, pseudoaneurysm, dissection, arteriovenous malformation, traumatic disruption)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1157 Endovascular/Endoluminal Stent Grafts	
34709	Placement of extension prosthesis(es) distal to the common iliac artery (ies) or proximal to the renal artery (ies) for endovascular repair of infrarenal abdominal aortic or iliac aneurysm, false aneurysm, dissection, penetrating ulcer, including pre-procedure sizing and device selection, all nonselective catheterization(s), all associated radiological supervision and interpretation and treatment zone angioplasty/stenting, when performed, per vessel treated (List separately in addition to code for primary procedure)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1157 Endovascular/Endoluminal Stent Grafts	

34710	Delayed placement of distal or proximal extension prosthesis for endovascular repair of infrarenal abdominal aortic or iliac aneurysm, false aneurysm, dissection, endoleak, or endograft migration, including pre-procedure sizing and device selection, all nonselective catheterization(s), all associated radiological supervision and interpretation and treatment zone angioplasty/stenting, when performed; initial vessel treated	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1157 Endovascular/Endoluminal Stent Grafts	
34711	Delayed placement of distal or proximal extension prosthesis for endovascular repair of infrarenal abdominal aortic or iliac aneurysm, false aneurysm, dissection, endoleak, or endograft migration, including pre-procedure sizing and device selection, all nonselective catheterization(s), all associated radiological supervision and interpretation and treatment zone angioplasty/stenting, when performed; each additional vessel treated (List separately in addition to code for primary procedure)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1157 Endovascular/Endoluminal Stent Grafts	
34712	Transcatheter delivery of enhanced fixation device(s) to the endograft (eg, anchor, screw, tack) and all associated radiological supervision and interpretation	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1157 Endovascular/Endoluminal Stent Grafts	
34713	Percutaneous access and closure of femoral artery for delivery of endograft through a large sheath (12 French or larger), including ultrasound guidance, when performed, unilateral (List separately in addition to code for primary procedure)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1157 Endovascular/Endoluminal Stent Grafts	
34714	Open femoral artery exposure with creation of conduit for delivery of endovascular prosthesis or for establishment of cardiopulmonary bypass, by groin incision, unilateral (List separately in addition to code for primary procedure)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1157 Endovascular/Endoluminal Stent Grafts	
34715	Open axillary/subclavian artery exposure for delivery of endovascular prosthesis by infraclavicular or supraclavicular incision, unilateral (List separately in addition to code for primary procedure)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1157 Endovascular/Endoluminal Stent Grafts	
34716	Open axillary/subclavian artery exposure with creation of conduit for delivery of endovascular prosthesis or for establishment of cardiopulmonary bypass, by infraclavicular or supraclavicular incision, unilateral (List separately in addition to code for primary procedure)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1157 Endovascular/Endoluminal Stent Grafts	
34808	Endovascular placement of Iliac artery occlusion device (List separately in addition to code for primary procedure)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1157 Endovascular/Endoluminal Stent Grafts	
34813	Placement of femoral-femoral prosthetic graft during endovascular aortic aneurysm repair (List separately in addition to code for primary procedure)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1157 Endovascular/Endoluminal Stent Grafts	
34830	Open repair of infrarenal aortic aneurysm or dissection, plus repair of associated arterial trauma, following unsuccessful endovascular repair; tube prosthesis	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1157 Endovascular/Endoluminal Stent Grafts	
34831	Open repair of infrarenal aortic aneurysm or dissection, plus repair of associated arterial trauma, following unsuccessful endovascular repair; aorto-bi-iliac prosthesis	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1157 Endovascular/Endoluminal Stent Grafts	
34841	Endovascular repair of visceral aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption) by deployment of a fenestrated visceral aortic endograft and all associated radiological supervision and interpretation, including target zone angioplasty, when performed; including one visceral artery endoprosthesis (superior mesenteric, celiac or renal artery)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1157 Endovascular/Endoluminal Stent Grafts	
34842	Endovascular repair of visceral aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption) by deployment of a fenestrated visceral aortic endograft and all associated radiological supervision and interpretation, including target zone angioplasty, when performed; including two visceral artery endoprostheses (superior mesenteric, celiac and/or renal artery[s])	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1157 Endovascular/Endoluminal Stent Grafts	
34843	Endovascular repair of visceral aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption) by deployment of a fenestrated visceral aortic endograft and all associated radiological supervision and interpretation, including target zone angioplasty, when performed; including three visceral artery endoprostheses (superior mesenteric, celia cand/or renal artery[s])	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1157 Endovascular/Endoluminal Stent Grafts	
34844	Endovascular repair of visceral aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption) by deployment of a fenestrated visceral aortic endograft and all associated radiological supervision and interpretation, including target zone angioplasty, when performed; including four or more visceral attery endoprostheses (superior mesenteric, celiac and/or renal artery[s])	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1157 Endovascular/Endoluminal Stent Grafts	
34845	Endovascular repair of visceral aorta and infrarenal abdominal aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption) with a fenestrated visceral aortic endograft and concomitant unibody or modular infrarenal aortic endograft and all associated radiological supervision and interpretation, including target zone angioplasty, when performed; including one visceral artery endoprosthesis (superior mesenteric, celiac or renal artery)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1157 Endovascular/Endoluminal Stent Grafts	
34846	Endovascular repair of visceral aorta and infrarenal abdominal aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption) with a fenestrated visceral aortic endograft and concomitant unibody or modular infrarenal aortic endograft and all associated radiological supervision and interpretation, including target zone angioplasty, when performed; including two visceral artery endoprostheses (superior mesenteric, celiac and/or renal artery[5])	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1157 Endovascular/Endoluminal Stent Grafts	
34847	Endovascular repair of visceral aorta and infrarenal abdominal aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption) with a fenestrated visceral aortic endograft and concomitant unibody or modular infrarenal aortic endograft and all associated radiological supervision and interpretation, including target zone angioplasty, when performed; including three visceral artery endoprostheses (superior mesenteric, celiac and/or renal artery[5])	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1157 Endovascular/Endoluminal Stent Grafts	

34848	Endovascular repair of visceral aorta and infrarenal abdominal aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption) with a fenestrated visceral aortic endograft and concomitant unibody or modular infrarenal aortic endograft and all associated radiological supervision and interpretation, including target zone angioplasty, when performed; including four or more visceral artery endoprostheses (superior mesenteric, celiac and/or renal artery[s])	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1157 Endovascular/Endoluminal Stent Grafts	
36228	Selective catheter placement, each intracranial branch of the internal carotid or vertebral arteries, unilateral, with angiography of the selected vessel circulation and all associated radiological supervision and interpretation (eg, middle cerebral artery, posterior inferior cerebellar artery) (List separately in addition to code for primary procedure)	Prior authorization is required.		
36245	Selective catheter placement, arterial system; each first order abdominal, pelvic, or lower extremity artery branch, within a vascular family	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1156 Treatment of Abnormal Uterine Bleeding and Fibroids	
36246	Selective catheter placement, arterial system; initial second order abdominal, pelvic, or lower extremity artery branch, within a vascular family	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1156 Treatment of Abnormal Uterine Bleeding and Fibroids	
36247	Selective catheter placement, arterial system; initial third order or more selective abdominal, pelvic, or lower extremity artery branch, within a vascular family	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1156 Treatment of Abnormal Uterine Bleeding and Fibroids	
36248	Selective catheter placement, arterial system; additional second order, third order and beyond, abdominal, pelvic, or lower extremity artery branch, within a vascular family (List in addition to code for initial second or third order vessel as appropriate)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1156 Treatment of Abnormal Uterine Bleeding and Fibroids	
36299	Unlisted Procedure: Vascular injection	Prior authorization is required.		
36465	Injection of non-compounded foam sclerosant with ultrasound compression maneuvers to guide dispersion of the injectate, inclusive of all imaging guidance and monitoring; single incompetent extremity truncal vein (eg, great saphenous vein, accessory saphenous vein)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1100 Surgical Treatment of Varicose Veins	
36466	Injection of non-compounded foam sclerosant with ultrasound compression maneuvers to guide dispersion of the injectate, inclusive of all imaging guidance and monitoring; multiple incompetent truncal veins (eg, great saphenous vein, accessory saphenous vein), same leg	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1100 Surgical Treatment of Varicose Veins	
36468	Injection(s) of sclerosant for spider veins (telangiectasia), limb or trunk	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1100 Surgical Treatment of Varicose Veins	
36470	Injection of sclerosant; single incompetent vein (other than telangiectasia)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1100 Surgical Treatment of Varicose Veins	
36471	Injection of sclerosant; multiple incompetent veins (other than telangiectasia), same leg	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1100 Surgical Treatment of Varicose Veins	
36473	Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, mechanochemical; first vein treated	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1100 Surgical Treatment of Varicose Veins	
36474	Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, mechanochemical; subsequent vein(s) treated in a single extremity, each through separate access sites (List separately in addition to code for primary procedure)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1100 Surgical Treatment of Varicose Veins	
36475	Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, radiofrequency; first vein treated	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1100 Surgical Treatment of Varicose Veins	
36476	Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, radiofrequency: subsequent vein(s) treated in a single extremity, each through separate access sites (List separately in addition to code for primary procedure)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1100 Surgical Treatment of Varicose Veins	
36478	Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, laser; first vein treated	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1100 Surgical Treatment of Varicose Veins	
36479	Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, laser; subsequent vein(s) treated in a single extremity, each through separate access sites (List separately in addition to code for primary procedure)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1100 Surgical Treatment of Varicose Veins	
36482	Endovenous ablation therapy of incompetent vein, extremity, by transcatheter delivery of a chemical adhesive (eg, cyanoacrylate) remote from the access site, inclusive of all imaging guidance and monitoring, percutaneous; first vein treated	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1100 Surgical Treatment of Varicose Veins	
36483	Endovenous ablation therapy of incompetent vein, extremity, by transcatheter delivery of a chemical adhesive (eg, cyanoacrylate) remote from the access site, inclusive of all imaging guidance and monitoring, percutaneous; subsequent vein(s) treated in a single extremity, each through separate access sites (List separately in addition to code for primary procedure)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1100 Surgical Treatment of Varicose Veins	
36511	Therapeutic apheresis; for white blood cells	Prior authorization is required.		
36901	Introduction of needle(s) and/or catheter(s), dialysis circuit, with diagnostic angiography of the dialysis circuit, including all direct puncture(s) and catheter placement(s), injection(s) of contrast, all necessary imaging from the arterial anastomosis and adjacent artery through entire venous outflow including the inferior or superior vena cava, fluoroscopic guidance, radiological supervision and interpretation and image documentation and report;	Prior authorization is required.		

36902	Introduction of needle(s) and/or catheter(s), dialysis circuit, with diagnostic angiography of the dialysis circuit, including all direct puncture(s) and catheter placement(s), injection(s) of contrast, all necessary imaging from the arterial anastomosis and adjacent artery through entire venous outflow including the inferior or superior vena cava, fluoroscopic guidance, radiological supervision and interpretation and image documentation and report, with transluminal balloon angioplasty, peripheral dialysis segment, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty	Prior authorization is required.	
36903	Introduction of needle(s) and/or catheter(s), dialysis circuit, with diagnostic angiography of the dialysis circuit, including all direct puncture(s) and catheter placement(s), injection(s) of contrast, all necessary imaging from the arterial anastomosis and adjacent artery through entire venous outflow including the inferior or superior vena cava, fluoroscopic guidance, radiological supervision and interpretation and image documentation and report; with transcatheter placement of intravascular stent(s), peripheral dialysis segment, including all imaging and radiological supervision and interpretation necessary to perform the stenting and all angioplasty within the peripheral dialysis segment	Prior authorization is required.	
36904	Percutaneous transluminal mechanical thrombectomy and/or infusion for thrombolysis, dialysis circuit, any method, including all imaging and radiological supervision and interpretation, diagnostic angiography, fluoroscopic guidance, catheter placement(s) and intraprocedural pharmacological thrombolytic injection(s);	Prior authorization is required.	
36905	Percutaneous transluminal mechanical thrombectomy and/or infusion for thrombolysis, dialysis circuit, any method, including all imaging and radiological supervision and interpretation, diagnostic angiography, fluoroscopic guidance, catheter placement(s) and intraprocedural pharmacological thrombolytic injection(s); with transluminal balloon angioplasty, peripheral dialysis segment, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty	Prior authorization is required.	
36906	Percutaneous transluminal mechanical thrombectomy and/or infusion for thrombolysis, dialysis circuit, any method, including all imaging and radiological supervision and interpretation, diagnostic angiography, fluoroscopic guidance, catheter placement(s) and intravarcular stent(s), peripheral dialysis segment, including all imaging and radiological supervision and interpretation necessary to perform the stenting and all angioplasty within the peripheral dialysis cruit	Prior authorization is required.	
36907	Transluminal balloon angioplasty, central dialysis segment, performed through dialysis circuit, including all imaging and radiological supervision and interpretation required to perform the angioplasty (List separately in addition to code for primary procedure)	Prior authorization is required.	
36908	Transcatheter placement of intravascular stent(s), central dialysis segment, performed through dialysis circuit, including all imaging and radiological supervision and interpretation required to perform the stenting and all angioplasty in the central dialysis segment (List separately in addition to code for primary procedure)	Prior authorization is required.	
36909	Dialysis circuit permanent vascular embolization or occlusion (including main circuit or any accessory veins), endovascular, including all imaging and radiological supervision and interpretation necessary to complete the intervention (List separately in addition to code for primary procedure)	Prior authorization is required.	
37211	Transcatheter therapy, arterial infusion for thrombolysis other than coronary or intracranial, any method, including radiological supervision and interpretation, initial treatment day	Prior authorization is required.	
37212	Transcatheter therapy, venous infusion for thrombolysis, any method, including radiological supervision and interpretation, initial treatment day	Prior authorization is required.	
37213	Transcatheter therapy, arterial or venous infusion for thrombolysis other than coronary, any method, including radiological supervision and interpretation, continued treatment on subsequent day during course of thrombolytic therapy, including follow-up catheter contrast injection, position change, or exchange, when performed;	Prior authorization is required.	
37214	Transcatheter therapy, arterial or venous infusion for thrombolysis other than coronary, any method, including radiological supervision and interpretation, continued treatment on subsequent day during course of thrombolytic therapy, including follow-up catheter contrast injection, position change, or exchange, when performed; cessation of thrombolysis including removal of catheter and vessel closure by any method	Prior authorization is required.	
37215	Transcatheter placement of intravascular stent(s), cervical carotid artery, open or percutaneous, including angioplasty, when performed and radiological supervision and interpretation; with distal embolic protection	Prior authorization is required.	
37216	Transcatheter placement of intravascular stent(s), cervical carotid artery, open or percutaneous, including angioplasty, when performed and radiological supervision and interpretation; without distal embolic protection	Prior authorization is required.	
37218	Transcatheter placement of intravascular stent(s), intrathoracic common carotid artery or innominate artery, open or percutaneous antegrade approach, including angioplasty, when performed and radiological supervision and interpretation	Prior authorization is required.	
37236	Transcatheter placement of an intravascular stent(s) (except lower extremity artery(s) for occlusive disease, cervical carotid, extracranial vertebral or intrathoracic carotid, intracranial, or coronary), open or percutaneous, including radiological supervision and interpretation and including all angioplasty within the same vessel, when performed; initial artery	Prior authorization is required.	

37237	Transcatheter placement of an intravascular stent(s) (except lower extremity artery(s) for occlusive disease, cervical carotid, extracranial vertebral or intrathoracic carotid, intracranial, or coronary), open or percutaneous, including radiological supervision and interpretation and including all angioplasty within the same vessel, when performed; each additional artery (List separately in addition to code for primary procedure)	Prior authorization is required.		
37243	Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping and imaging guidance necessary to complete the intervention; for tumors, organ ischemia, or infarction	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1156 Treatment of Abnormal Uterine Bleeding and Fibroids and HHO-DE-MP-1158 Treatment of Prostate	
37244	Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping and imaging guidance necessary to complete the intervention; for arterial or venous hemorrhage or lymphatic extravasation	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1156 Treatment of Abnormal Uterine Bleeding and Fibroids	
37246	Transluminal balloon angioplasty (except lower extremity artery(ies) for occlusive disease, intracranial, coronary, pulmonary, or dialysis circuit), open or percutaneous, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty within the same artery; initial artery	Prior authorization is required.		
37247	Transluminal balloon angioplasty (except lower extremity artery(ies) for occlusive disease, intracranial, coronary, pulmonary, or dialysis circuit), open or percutaneous, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty within the same artery; each additional artery (List separately in addition to code for primary procedure)	Prior authorization is required.		
37500	Vascular endoscopy, surgical, with ligation of perforator veins, subfascial (SEPS)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1100 Surgical Treatment of Varicose Veins	
37501	Unlisted vascular endoscopy procedure	Prior authorization is required.		
37700	Ligation and division of long saphenous vein at saphenofemoral junction, or distal	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1100 Surgical Treatment of Varicose Veins	
37718	interruptions Ligation, division and stripping, short saphenous vein	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1100 Surgical Treatment of Varicose Veins	
37722	Ligation, division and stripping, long (greater) saphenous veins from saphenofemoral			
3//22	junction to knee or below	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1100 Surgical Treatment of Varicose Veins	
37735	Ligation and division and complete stripping of long or short saphenous veins with radical excision of ulcer and skin graft and/or interruption of communicating veins of lower leg, with excision of deep fascia	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1100 Surgical Treatment of Varicose Veins	
37760	Ligation of perforator veins, subfascial, radical (Linton type), including skin graft, when performed, open,1 leg	Prior authorization is required.		
37761	Ligation of perforator vein(s), subfascial, open, including ultrasound guidance, when performed, 1 leg	Prior authorization is required.		
37765	Stab phlebectomy of varicose veins, 1 extremity; 10-20 stab incisions	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1100 Surgical Treatment of Varicose Veins	
37766	Stab phlebectomy of varicose veins, 1 extremity; more than 20 incisions	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1100 Surgical Treatment of Varicose Veins	
37780	Ligation and division of short saphenous vein at saphenopopliteal junction (separate procedure)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1100 Surgical Treatment of Varicose Veins	
37785	Ligation, division and/or excision of varicose vein cluster(s), 1 leg	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1100 Surgical Treatment of Varicose Veins	
37799	Unlisted procedure, vascular surgery	Prior authorization is required. Reference policies for additional information. Prior authorization is required for not otherwise classified codes.	HHO-DE-MP-1157 Endovascular/Endoluminal Stent Grafts and HHO-DE-MP-1100 Surgical Treatment of Varicose Veins	
38129	Unlisted laparoscopy procedure, spleen	Prior authorization is required for hot other wise classified codes.	HHO-DE-IVIP-1100 Surgical Treatment of Varicose Venis	
38206	Blood-derived hematopoietic progenitor cell harvesting for transplantation, per collection; autologous	Prior authorization is required. Reference policies for additional information.	Hematopoietic Cell Transplantation in Treatment of Germ-Cell Tumors HHO-DE-MP-1119, Hematopoietic Cell Transplantation in Waldenstrom Macroglobulinemia HHO-DE- MP-1121, Orthopedic Applications of Stem-Cell Therapy HHO- DE-MP-1122, Hematopoietic Cell Transplantation (HCT) for Autoimmune Diseases HHO-DE-MP-1103, Hematopoietic Cell Transplantation for CNS Embryonal Tumors and Ependymoma HHO-DE-MP-1107, Hematopoietic Cell Transplantation for Solid Tumors of Childhood Surgery HHO-DE-MP-1118	
38230	Bone marrow harvesting for transplantation; allogeneic	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1122 Orthopedic Applications of Stem-Cell Therapy, HHO-DE-MP-1121 Hematopoietic Cell Transplantation in Waldenstrom Macroglobulinemia, HHO-DE- MP-1118 Hematopoietic Cell Transplantation for Solid Tumors of Childhood Surgery, HHO-DE-MP-1113 Hematopoietic Cell Transplantation from Chronic Myeloid Leukemia, HHO-DE-MP- 1107 Hematopoietic Cell Transplantation for CNS Embryonal Tumors and Ependymoma, HHO-DE-MP-1103 Hematopoietic Cell Transplantation (HCT) for Autoimmune Diseases, or HHO- DE-MP-1098 Allogeneic Hematopoietic Cell Transplantation for Genetic Diseases and Acquired Anemia	

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

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

tr 43253 age				
43253 age	ophagogastroduodenoscopy, flexible, transoral; with transendoscopic ultrasound-guided ransmural injection of diagnostic or therapeutic substance(s) (eg, anesthetic, neurolytic		HHO-DE-MP-1139 Transesophageal Endoscopic Therapies for	
	ent) or fiducial marker(s) (includes endoscopic ultrasound examination of the esophagus,	Prior authorization is required. Reference policies for additional information.	Gastroesophageal Reflux Disease and HHO-DE-MP-1217 Upper	
	stomach and either the duodenum or a surgically altered stomach where the jejunum is	Phot authorization is required. Reference poncies for auditional mormation.	Gastrointestinal Endoscopy (EGD)	
	examined distal to the anastomosis)			
43254 E	Esophagogastroduodenoscopy, flexible, transoral; with endoscopic mucosal resection	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1217 Upper Gastrointestinal Endoscopy (EGD)	
43255 Es	sophagogastroduodenoscopy, flexible, transoral; with control of bleeding, any method	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1217 Upper Gastrointestinal Endoscopy (EGD)	
Es	sophagogastroduodenoscopy, flexible, transoral; with delivery of thermal energy to the		HHO-DE-MP-1139 Transesophageal Endoscopic Therapies for	
43257	muscle of lower esophageal sphincter and/or gastric cardia, for treatment of	Prior authorization is required. Reference policies for additional information.	Gastroesophageal Reflux Disease and HHO-DE-MP-1217 Upper	
	gastroesophageal reflux disease		Gastrointestinal Endoscopy (EGD)	
	Esophagogastroduodenoscopy, flexible, transoral; with endoscopic ultrasound			
43259 ex	xamination, including the esophagus, stomach and either the duodenum or a surgically	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1217 Upper Gastrointestinal Endoscopy (EGD)	
	altered stomach where the jejunum is examined distal to the anastomosis			
43260 End	doscopic retrograde cholangiopancreatography (ERCP); diagnostic, including collection of	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1217 Upper Gastrointestinal Endoscopy (EGD)	
	specimen(s) by brushing or washing, when performed (separate procedure)			
43261 En	ndoscopic retrograde cholangiopancreatography (ERCP); with biopsy, single or multiple	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1217 Upper Gastrointestinal Endoscopy (EGD)	
43262	Endoscopic retrograde cholangiopancreatography (ERCP); with	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1217 Upper Gastrointestinal Endoscopy (EGD)	
	sphincterotomy/papillotomy			
43263 End	ndoscopic retrograde cholangiopancreatography (ERCP); with pressure measurement of sphincter of Oddi	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1217 Upper Gastrointestinal Endoscopy (EGD)	
Fr	ndoscopic retrograde cholangiopancreatography (ERCP); with removal of calculi/debris			
43264	from biliary/pancreatic duct(s)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1217 Upper Gastrointestinal Endoscopy (EGD)	
Er	ndoscopic retrograde cholangiopancreatography (ERCP); with destruction of calculi, any			
43265	method (eg, mechanical, electrohydraulic, lithotripsy)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1217 Upper Gastrointestinal Endoscopy (EGD)	
			HHO-DE-MP-1139 Transesophageal Endoscopic Therapies for	
43266 E	Esophagogastroduodenoscopy, flexible, transoral; with placement of endoscopic stent	Prior authorization is required. Reference policies for additional information.	Gastroesophageal Reflux Disease and HHO-DE-MP-1217 Upper	
	(includes pre- and post-dilation and guide wire passage, when performed)		Gastrointestinal Endoscopy (EGD)	
5.	sophagogastroduodenoscopy, flexible, transoral; with ablation of tumor(s), polyp(s), or			
	ther lesion(s) (includes pre- and post-dilation and guide wire passage, when performed)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1217 Upper Gastrointestinal Endoscopy (EGD)	
	ndoscopic retrograde cholangiopancreatography (ERCP); with placement of endoscopic			
43274 ster	nt into biliary or pancreatic duct, including pre- and post-dilation and guide wire passage,	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1217 Upper Gastrointestinal Endoscopy (EGD)	
├	when performed, including sphincterotomy, when performed, each stent			
43275 End	adoscopic retrograde cholangiopancreatography (ERCP); with removal of foreign body(s)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1217 Upper Gastrointestinal Endoscopy (EGD)	
l	or stent(s) from biliary/pancreatic duct(s)			
	ndoscopic retrograde cholangiopancreatography (ERCP); with removal and exchange of			
	ent(s), biliary or pancreatic duct, including pre- and post-dilation and guide wire passage,	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1217 Upper Gastrointestinal Endoscopy (EGD)	
	when performed, including sphincterotomy, when performed, each stent exchanged			
En	ndoscopic retrograde cholangiopancreatography (ERCP); with trans-endoscopic balloon			
43277	dilation of biliary/pancreatic duct(s) or of ampulla (sphincteroplasty), including	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1217 Upper Gastrointestinal Endoscopy (EGD)	
	sphincterotomy, when performed, each duct			
	Endoscopic retrograde cholangiopancreatography (ERCP); with ablation of tumor(s),			
43278 po	olyp(s), or other lesion(s), including pre- and post-dilation and guide wire passage, when	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1217 Upper Gastrointestinal Endoscopy (EGD)	
	performed			
	Laparoscopy, surgical, esophageal sphincter augmentation procedure, placement of			
	hincter augmentation device (ie, magnetic band), including cruroplasty when performed	Prior authorization is required.		
43285	Removal of esophageal sphincter augmentation device	Prior authorization is required.		
43285	Unlisted laparoscopy procedure, esophagus	Prior authorization is required. Prior authorization is required for not otherwise classified codes.	+	
	onisten iaharoscohk hiorennie, esohiragus	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1139 Transesophageal Endoscopic Therapies for	
43499	Unlisted procedure, esophagus	Prior authorization is required for not otherwise classified codes.	Gastroesophageal Reflux Disease	
43640	Vagotomy including pyloroplasty, with or without gastrostomy; truncal or selective	Prior authorization is required.		
	Vagotomy including pylotoplasty, with or without gastrostomy; truited of selective Vagotomy including pylotoplasty, with or without gastrostomy; parietal cell (highly			
43641	selective)	Prior authorization is required.		
L	Laparoscopy, surgical, gastric restrictive procedure; with gastric bypass and Roux-en-Y	Defensively standing to service a Defension and the standard standing to the	LILLO DE MO 1004 Paristria Guaran	
12614	gastroenterostomy (roux limb 150 cm or less)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1004 Bariatric Surgery	
43644				
43644	paroscopy, surgical, gastric restrictive procedure; with gastric by pass and small intestine	Prior authorization is required. Reference policies for additional information	HHO-DE-MP-1004 Pariatric Surgery	
43644 43645	reconstruction to limit absorption	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1004 Bariatric Surgery	
43644 43645	reconstruction to limit absorption aparoscopy, surgical; implantation or replacement of gastric neurostimulator electrodes,		HHO-DE-MP-1235 Gastric Electrical Stimulation and Gastric	
43644 43645	reconstruction to limit absorption	Prior authorization is required. Reference policies for additional information. Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1235 Gastric Electrical Stimulation and Gastric Pacing	
43644 43645 Lap 43647 Lap	reconstruction to limit absorption aparoscopy, surgical; implantation or replacement of gastric neurostimulator electrodes, antrum	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1235 Gastric Electrical Stimulation and Gastric Pacing HHO-DE-MP-1235 Gastric Electrical Stimulation and Gastric	
43644 43645 Lap 43647 Lap 43648 La	reconstruction to limit absorption paroscopy, surgical; implantation or replacement of gastric neurostimulator electrodes, antrum aparoscopy, surgical; revision or removal of gastric neurostimulator electrodes, antrum	Prior authorization is required. Reference policies for additional information. Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1235 Gastric Electrical Stimulation and Gastric Pacing	
43644 Lap 43645 Lap 43647 Lap 43648 La 43651 Lap	reconstruction to limit absorption aparoscopy, surgical; implantation or replacement of gastric neurostimulator electrodes, antrum aparoscopy, surgical; revision or removal of gastric neurostimulator electrodes, antrum Laparoscopy, surgical; transection of vagus nerves, truncal	Prior authorization is required. Reference policies for additional information. Prior authorization is required. Reference policies for additional information. Prior authorization is required.	HHO-DE-MP-1235 Gastric Electrical Stimulation and Gastric Pacing HHO-DE-MP-1235 Gastric Electrical Stimulation and Gastric	
43644 43645 Lap 43647 Lap 43648 La	reconstruction to limit absorption paroscopy, surgical; implantation or replacement of gastric neurostimulator electrodes, antrum aparoscopy, surgical; revision or removal of gastric neurostimulator electrodes, antrum	Prior authorization is required. Reference policies for additional information. Prior authorization is required. Reference policies for additional information. Prior authorization is required. Prior authorization is required.	HHO-DE-MP-1235 Gastric Electrical Stimulation and Gastric Pacing HHO-DE-MP-1235 Gastric Electrical Stimulation and Gastric Pacing	
43644 43645 Lap 43647 Lap 43648 La 43651 Lap	reconstruction to limit absorption aparoscopy, surgical; implantation or replacement of gastric neurostimulator electrodes, antrum aparoscopy, surgical; revision or removal of gastric neurostimulator electrodes, antrum Laparoscopy, surgical; transection of vagus nerves, truncal	Prior authorization is required. Reference policies for additional information. Prior authorization is required. Reference policies for additional information. Prior authorization is required. Prior authorization is required. Prior authorization is required. Prior authorization is required.	HHO-DE-MP-1235 Gastric Electrical Stimulation and Gastric Pacing HHO-DE-MP-1235 Gastric Electrical Stimulation and Gastric Pacing HHO-DE-MP-1139 Transesophageal Endoscopic Therapies for	
43644 43645 Lap 43647 Lap 43648 La 43651 43652 43659	reconstruction to limit absorption aparoscopy, surgical; implantation or replacement of gastric neurostimulator electrodes, antrum aparoscopy, surgical; revision or removal of gastric neurostimulator electrodes, antrum Laparoscopy, surgical; transection of vagus nerves, truncal Laparoscopy, surgical; transection of vagus nerves, selective or highly selective Unlisted laparoscopy procedure, stomach	Prior authorization is required. Reference policies for additional information. Prior authorization is required. Reference policies for additional information. Prior authorization is required. Prior authorization is required.	HHO-DE-MP-1235 Gastric Electrical Stimulation and Gastric Pacing HHO-DE-MP-1235 Gastric Electrical Stimulation and Gastric Pacing	
43644 43645 Lap 43647 Lap 43648 La 43651 43652 43659	reconstruction to limit absorption aparoscopy, surgical; implantation or replacement of gastric neurostimulator electrodes, antrum aparoscopy, surgical; revision or removal of gastric neurostimulator electrodes, antrum Laparoscopy, surgical; transection of vagus nerves, truncal Laparoscopy, surgical; transection of vagus nerves, selective or highly selective Unlisted laparoscopy procedure, stomach Laparoscopy, surgical, gastric restrictive procedure; placement of adjustable gastric	Prior authorization is required. Reference policies for additional information. Prior authorization is required. Reference policies for additional information. Prior authorization is required. Prior authorization is required. Prior authorization is required. Prior authorization is required.	HHO-DE-MP-1235 Gastric Electrical Stimulation and Gastric Pacing HHO-DE-MP-1235 Gastric Electrical Stimulation and Gastric Pacing HHO-DE-MP-1139 Transesophageal Endoscopic Therapies for	
43644 43645 Lap 43647 Lap 43648 Lap 43651 43652 43659 43770	reconstruction to limit absorption aparoscopy, surgical; implantation or replacement of gastric neurostimulator electrodes, antrum aparoscopy, surgical; revision or removal of gastric neurostimulator electrodes, antrum Laparoscopy, surgical; transection of vagus nerves, truncal Laparoscopy, surgical; transection of vagus nerves, selective or highly selective Unlisted laparoscopy procedure, stomach	Prior authorization is required. Reference policies for additional information. Prior authorization is required. Reference policies for additional information. Prior authorization is required. Prior authorization is required. Prior authorization is required. Prior authorization is required. Authorization is required to required. Prior authorization is required. Prior authorization is required. Prior authorization is required.	HHO-DE-MP-1235 Gastric Electrical Stimulation and Gastric Pacing HHO-DE-MP-1235 Gastric Electrical Stimulation and Gastric Pacing HHO-DE-MP-1139 Transesophageal Endoscopic Therapies for Gastroesophageal Reflux Disease	

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43772	Laparoscopy, surgical, gastric restrictive procedure; removal of adjustable gastric restrictive device component only	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1004 Bariatric Surgery
43773	Laparoscopy, surgical, gastric restrictive procedure; removal and replacement of adjustable gastric restrictive device component only	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1004 Bariatric Surgery
43774	Laparoscopy, surgical, gastric restrictive procedure; removal of adjustable gastric restrictive device and subcutaneous port components	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1004 Bariatric Surgery
43775	Laparoscopy, surgical, gastric restrictive procedure; longitudinal gastrectomy (ie, sleeve gastrectomy)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1004 Bariatric Surgery
43842	Gastric restrictive procedure, without gastric bypass, for morbid obesity; vertical-banded gastroplasty	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1004 Bariatric Surgery
43843	Gastric restrictive procedure, without gastric by pass, for morbid obesity; other than vertical- banded gastroplasty	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1004 Bariatric Surgery
43845	Gastric restrictive procedure with partial gastrectomy, pylorus-preserving duodenoileostomy and ileoileostomy (50 to 100 cm common channel) to limit absorption (biliopancreatic diversion with duodenal switch)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1004 Bariatric Surgery
43846	Gastric restrictive procedure, with gastric bypass for morbid obesity; with short limb (150 cm or less) Roux-en-Y gastroenterostomy	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1004 Bariatric Surgery
43847	Gastric restrictive procedure, with gastric bypass for morbid obesity; with small intestine reconstruction to limit absorption	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1004 Bariatric Surgery
43848	Revision, open, of gastric restrictive procedure for morbid obesity, other than adjustable gastric restrictive device (separate procedure)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1004 Bariatric Surgery
43881	Implantation or replacement of gastric neurostimulator electrodes, antrum, open	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1235 Gastric Electrical Stimulation and Gastric Pacing
43882	Revision or removal of gastric neurostimulator electrodes, antrum, open	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1235 Gastric Electrical Stimulation and Gastric Pacing
43886	Gastric restrictive procedure, open; revision of subcutaneous port component only	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1004 Bariatric Surgery
43887	Gastric restrictive procedure, open; removal of subcutaneous port component only	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1004 Bariatric Surgery
43888	Gastric restrictive procedure, open, removal and replacement of subcutaneous port component only	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1004 Bariatric Surgery
42000		Prior authorization is required for not otherwise classified codes. Reference policies for	HHO-DE-MP-1139 Transesophageal Endoscopic Therapies for
43999	Unlisted procedure, stomach	additional information.	Gastroesophageal Reflux Disease HHO-DE-MP-1051 Small Bowel, Liver and Multivisceral
44133	Donor enterectomy (including cold preservation), open; partial, from living donor	Prior authorization is required. Reference policies for additional information.	Transplantation HHO-DE-MP-1051 Small Bowel, Liver and Multivisceral
44135	Intestinal allotransplantation; from cadaver donor	Prior authorization is required. Reference policies for additional information.	Transplantation HHO-DE-MP-1051 Small Bowel, Liver and Multivisceral
44136	Intestinal allotransplantation; from living donor Laparoscopic procedure: Intestine (except rectum)	Prior authorization is required. Reference policies for additional information. Prior authorization is required.	Transplantation
44238	Preparation of fecal microbiota for instillation, including assessment of donor specimen	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1146 Fecal Microbiota Transplantation
44703	Unlisted procedure, small intestine	Prior authorization is required. Reference policies for additional information. Prior authorization is required. Reference policies for additional information. Prior authorization is required for not otherwise classified codes.	HHO-DE-MP-1146 Fecal Microbiota Transplantation DE-MP-1146 Fecal Microbiota Transplantation and HHO- DE-MP-1051 Small Bowel, Liver and Multivisceral
44899	Unlisted procedure, Meckel's diverticulum and the mesentery	Prior authorization is required to not other wise classified codes.	Transplantation
44979	Unlisted laparoscopy procedure, appendix	Prior authorization is required.	
45399	Unlisted procedure, colon	Prior authorization is required.	
45499	Unlisted laparoscopy procedure, rectum	Prior authorization is required.	
45999	Unlisted procedure, rectum	Prior authorization is required.	
46999	Unlisted procedure, anus	Prior authorization is required.	
47135	Liver allotransplantation, orthotopic, partial or whole, from cadaver or living donor, any age	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1124 Liver Transplant and HHO-DE-MP-1051 Small Bowel, Liver and Multivisceral Transplantation
47370	Laparoscopy, surgical, ablation of 1 or more liver tumor(s); radiofrequency	Prior authorization is required.	
47371	Laparoscopy, surgical, ablation of 1 or more liver tumor(s); cryosurgical	Prior authorization is required.	
47379	Laparoscopy procedure: Liver	Prior authorization is required.	
47380	Ablation, open, of 1 or more liver tumor(s); radiofrequency	Prior authorization is required.	
47381	Ablation, open, of 1 or more liver tumor(s); cryosurgical	Prior authorization is required.	
47382	Ablation, 1 or more liver tumor(s), percutaneous, radiofrequency	Prior authorization is required.	
47383	Ablation, 1 or more liver tumor(s), percutaneous, rayoablation	Prior authorization is required.	
47399	Unlisted procedure, liver	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1124 Liver Transplant and HHO-DE-MP-1051 Small Bowel, Liver and Multivisceral Transplantation
47579	Unlisted laparoscopy procedure, biliary tract	Prior authorization is required.	
47999	Unlisted procedure, biliary tract	Prior authorization is required.	
48160	Pancreatectomy, total or subtotal, with autologous transplantation of pancreas or pancreatic islet cells	Prior authorization is required for transplants. Reference policies for additional information.	HHO-DE-MP-1021 Islet Cell Transplantation
48550	Donor pancreatectomy (including cold preservation), with or without duodenal segment for transplantation	Prior authorization is required.	
48554	Transplantation of pancreatic allograft	Prior authorization is required.	
48556	Removal of transplanted pancreatic allograft	Prior authorization is required.	
48999	Unlisted procedure, pancreas	Prior authorization is required.	
49329	Laparoscopy procedure: Abdomen, peritoneum, omentum	Prior authorization is required.	
49659	Laparoscopic procedure: Hernioplasty, herniography, herniotomy	Prior authorization is required.	
49999	Procedure: Abdomen, peritoneum and omentum	Prior authorization is required.	
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50250	Ablation, open, 1 or more renal mass lesion(s), cryosurgical, including intraoperative ultrasound guidance and monitoring. if performed	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1218 Radiofrequency Ablation of Miscellaneous Solid Tumors	
50320	Donor nephrectomy (including cold preservation); open, from living donor	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1017 Kidney Transplant	
50340	Recipient nephrectomy (separate procedure)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1017 Kidney Transplant	
50360	Renal allotransplantation, implantation of graft; without recipient nephrectomy	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1017 Kidney Transplant	
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50365	Renal allotransplantation, implantation of graft; with recipient nephrectomy	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1017 Kidney Transplant	
50370	Removal of transplanted renal allograft	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1017 Kidney Transplant	
50380	Renal autotransplantation, reimplantation of kidney	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1017 Kidney Transplant	
50542	Laparoscopy, surgical; ablation of renal mass lesion(s), including intraoperative ultrasound guidance and monitoring, when performed	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1218 Radiofrequency Ablation of Miscellaneous Solid Tumors	
50547	Laparoscopy, surgical; donor nephrectomy (including cold preservation), from living donor	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1017 Kidney Transplant	
50549	Unlisted laparoscopy procedure, renal	Prior authorization is required.		
50592	Ablation, 1 or more renal tumor(s), percutaneous, unilateral, radiofrequency	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1218 Radiofrequency Ablation of Miscellaneous Solid Tumors	
50593	Ablation, renal tumor(s), unilateral, percutaneous, cryotherapy	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1218 Radiofrequency Ablation of Miscellaneous Solid Tumors	
50949	Unlisted laparoscopy procedure, ureter	Prior authorization is required.		
51999	Laparoscopy procedure: Bladder	Prior authorization is required.		
	Cystourethroscopy, with insertion of permanent adjustable transprostatic implant; single			
52441	implant	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1158 Treatment of Prostate	
52442	Cystourethroscopy, with insertion of permanent adjustable transprostatic implant; each additional permanent adjustable transprostatic implant (List separately in addition to code for orimatry procedure)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1158 Treatment of Prostate	
52450	Transurethral incision of prostate	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1158 Treatment of Prostate	
	Transurethral electrosurgical resection of prostate, including control of postoperative			
52601	bleeding, complete (vasectomy, neatotomy, cystourethroscopy, urethral calibration and/or dilation and internal urethrotomy are included)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1158 Treatment of Prostate	
52630	Transurethral resection; residual or regrowth of obstructive prostate tissue including control of postoperative bleeding, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation and internal urethrotomy are included)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1158 Treatment of Prostate	
52640	Transurethral resection; of postoperative bladder neck contracture	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1158 Treatment of Prostate	
52010	Laser coagulation of prostate, including control of postoperative bleeding, complete	The denoted of stellar car held ence ponetes for deartonial mormation.	into be ini 1156 il danich of Hostale	
52647	(vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation and internal urethrotomy are included if performed)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1158 Treatment of Prostate	
52648	Laser vaporization of prostate, including control of postoperative bleeding, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, internal urethrotomy and transurethral resection of prostate are included if performed)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1158 Treatment of Prostate	
52649	Laser enucleation of the prostate with morcellation, including control of postoperative bleeding, complete (vasectormy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, internal urethrotomy and transurethral resection of prostate are included if performed)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1158 Treatment of Prostate	
53850	Transurethral destruction of prostate tissue; by microwave thermotherapy	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1158 Treatment of Prostate	
53852	Transurethral destruction of prostate tissue; by radiofrequency thermotherapy	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1158 Treatment of Prostate	
53854	Transurethral destruction of prostate tissue; by radiofrequency generated water vapor	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1158 Treatment of Prostate	
53855	thermotherapy Insertion of a temporary prostatic urethral stent, including urethral measurement	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1158 Treatment of Prostate	
13017	macraon or a temporary prostatic urcunaristent, including urcuital medsurement		into-be-wir-1156 meatment of mostale	
53899	Unlisted procedure, urinary system	Prior authorization is required for not otherwise classified codes. Reference policies for	HHO-DE-MP-1117 Urinary Incontinence Therapy	
54655		additional information.		
54699	Laporoscopic procedure: Testis	Prior authorization is required.		
55200	Vasotomy, cannulization with or without incision of vas, unilateral or bilateral (separate procedure)	Prior authorization and a signed consent of awareness form is required. Sterilization is not covered for members under age 21.		
55250	Vasectomy, unilateral or bilateral (separate procedure), including postoperative semen examination(s)	Prior authorization and a signed consent of awareness form is required. Sterilization is not covered for members under age 21.		
55300	Vasotomy for vasograms, seminal vesiculograms, or epididymograms, unilateral or bilateral	Prior authorization and a signed consent of awareness form is required. Sterilization is not covered for members under age 21.		
55559	Laparoscopy procedure: Spermatic cord	Prior authorization is required.		
	Prostatectomy, perineal, subtotal (including control of postoperative bleeding, vasectomy,	·		
55801		Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1158 Treatment of Prostate	
55010	meatotomy, urethral calibration and/or dilation and internal urethrotomy)		UNO DE MD 1150 Terreterent «fibere»	
55810 55812	Prostatectomy, perineal radical; Prostatectomy, perineal radical; with lymph node biopsy(s) (limited pelvic	Prior authorization is required. Reference policies for additional information. Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1158 Treatment of Prostate HHO-DE-MP-1158 Treatment of Prostate	
33012	lymphadenectomy)	First automation is required. Reletence poncies for additional information.	mio-DE-WF-1156 freatment of Prostate	
	Prostatectomy, peripeal radical; with bilateral pelvic lymphadepectomy, including external			
55815	Prostatectomy, perineal radical; with bilateral pelvic lymphadenectomy, including external iliac, hypogastric and obturator nodes Prostatectomy (including control of postoperative bleeding, vasectomy, meatotomy,	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1158 Treatment of Prostate	
55815		Prior authorization is required. Reference policies for additional information. Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1158 Treatment of Prostate HHO-DE-MP-1158 Treatment of Prostate	
	iliac, hypogastric and obturator nodes Prostatectomy (including control of postoperative bleeding, vasectomy, meatotomy, urethral calibration and/or dilation and internal urethrotomy); suprapubic, subtotal, 1 or 2	· · · ·		

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

58570	Laparoscopy, surgical, with total hysterectomy, for uterus 250 g or less	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1216 Gender Affirmation Services	
58571	Laparoscopy, surgical, with total hysterectomy, for uterus 250 g or less; with removal of tube(s) and/or ovary(s)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1216 Gender Affirmation Services	
58572	Laparoscopy, surgical, with total hysterectomy, for uterus greater than 250 g	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1216 Gender Affirmation Services	
58573	Laparoscopy, surgical, with total hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1216 Gender Affirmation Services	
58578	Laparoscopy procedure: Uterus	Prior authorization is required.		
58579	Laparoscopy procedure: Uterus	Prior authorization is required.		
58600	Ligation or transection of fallopian tube(s), abdominal or vaginal approach, unilateral or bilateral	Prior authorization and a signed consent of awareness form is required. Sterilization is not covered for members under age 21.		
58605	Ligation or transection of fallopian tube(s), abdominal or vaginal approach, postpartum, unilateral or bilateral, during same hospitalization (separate procedure)	Prior authorization and a signed consent of awareness form is required. Sterilization is not covered for members under age 21.		
	Ligation or transection of fallopian tube(s) when done at the time of cesarean delivery or			
58611	intra-abdominal surgery (not a separate procedure) (List separately in addition to code for primary procedure)	Prior authorization and a signed consent of awareness form is required. Sterilization is not covered for members under age 21.		
58661	Laparoscopy, surgical; with removal of adnexal structures (partial or total oophorectomy and/or salpingectomy)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1216 Gender Affirmation Services	
58671	Laparoscopy, surgical; with occlusion of oviducts by device (eg, band, clip, or Falope ring)	Prior authorization and a signed consent of awareness form is required. Sterilization is not covered for members under age 21.		
58674	Laparoscopy, surgical, ablation of uterine fibroid(s) including intraoperative ultrasound	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1156 Treatment of Abnormal Uterine Bleeding and Fibroids	
58679	guidance and monitoring, radiofrequency Laparoscopy procedure: Ovary	Prior authorization is required.		
58679	Salpingo-oophorectomy, complete or partial, unilateral or bilateral (separate procedure)	Prior authorization is required. Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1216 Gender Affirmation Services	
58940	Salpingo-oophorectomy, complete or partial, unilateral or bilateral (separate procedure) Oophorectomy, partial or total, unilateral or bilateral;	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1216 Gender Affirmation Services	
	coprorectomy, partial or total, unilateral or bilateral;	Prior authorization is required. Reference policies for additional information. Prior authorization is required. Reference policies for additional information.		
58999	Unlisted procedure, female genital system (nonobstetrical)	Prior authorization is required, kelerence policies for additional information. Prior authorization is required for not otherwise classified codes.	HHO-DE-MP-1215 Labiaplasty	
59001	Amniocentesis; therapeutic amniotic fluid reduction (includes ultrasound guidance)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1043 Treatment of Twin-Twin Transfusion Syndrome with Amnioreduction and/or Fetoscopic Laser Therapy	
59076	Fetal shunt placement, including ultrasound guidance	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1110 Fetal Surgery for Prenatally Diagnosed Malformations	
59840	Induced abortion, by dilation and curettage	Prior authorization is required. Elective abortions are not covered.		
59841	Induced abortion, by dilation and evacuation	Prior authorization is required. Elective abortions are not covered.		
59850	Induced abortion, by 1 or more intra-amniotic injections (amniocentesis-injections), including hospital admission and visits, delivery of fetus and secundines;	Prior authorization is required. Elective abortions are not covered.		
59851	Induced abortion, by 1 or more intra-amniotic injections (amniocentesis-injections), including hospital admission and visits, delivery of fetus and secundines; with dilation and curettage and/or evacuation	Prior authorization is required. Elective abortions are not covered.		
59852	Induced abortion, by 1 or more intra-amniotic injections (amniocentesis-injections), including hospital admission and visits, delivery of fetus and secundines; with hysterotomy (failed intra-amniotic injection)	Prior authorization is required. Elective abortions are not covered.		
59855	Induced abortion, by 1 or more vaginal suppositories (eg, prostaglandin) with or without cervical dilation (eg, laminaria), including hospital admission and visits, delivery of fetus and secundines;	Prior authorization is required. Elective abortions are not covered.		
59856	Induced abortion, by 1 or more vaginal suppositories (eg, prostaglandin) with or without cervical dilation (eg, laminaria), including hospital admission and visits, delivery of fetus and secundines; with dilation and curettage and/or evacuation	Prior authorization is required. Elective abortions are not covered.		
59857	Induced abortion, by 1 or more vaginal suppositories (eg, prostaglandin) with or without cervical dilation (eg, laminaria), including hospital admission and visits, delivery of fetus and secundines; with hysterotomy (failed medical evacuation)	Prior authorization is required. Elective abortions are not covered.		
59866	Multifetal pregnancy reduction(s) (MPR)	Prior authorization is required. Elective abortions are not covered.		
59897	Unlisted fetal invasive procedure, including ultrasound guidance, when performed	Prior authorization is required. Reference policies for additional information. Prior authorization is required for not otherwise classified codes.	HHO-DE-MP-1110 Fetal Surgery for Prenatally Diagnosed Malformations	
59898	Unlisted laparoscopy procedure, maternity care and delivery	Prior authorization is required.		
59899	Unlisted procedure, maternity care and delivery	Prior authorization is required.		
60659	Unlisted laparoscopy procedure, endocrine system	Prior authorization is required.		
60699	Unlisted procedure, endocrine system	Prior authorization is required.		
61520	Craniectomy for excision of brain tumor, infratentorial or posterior fossa; cerebellopontine angle tumor	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1190 External Hearing Aids, Auditory Brainstem Implant, Bone-Anchored Hearing Devices and Audiological Testing	
61530	Craniectomy, bone flap craniotomy, transtemporal (mastoid) for excision of cerebellopontine angle tumor; combined with middle/posterior fossa craniotomy/craniectomy	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1190 External Hearing Aids, Auditory Brainstem Implant, Bone-Anchored Hearing Devices and Audiological Testing	
61598	Transpetrosal approach to posterior cranial fossa, clivus or foramen magnum, including ligation of superior petrosal sinus and/or sigmoid sinus	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1190 External Hearing Aids, Auditory Brainstem Implant, Bone-Anchored Hearing Devices and Audiological Testing	
61850	Twist drill or burr hole(s) for implantation of neurostimulator electrodes, cortical	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1009 Deep Brain Stimulation and HHO-DE-MP- 1131 Responsive Neurostimulation for the Treatment of Refractory Partial Epilepsy	

			HHO DE MD 1000 Doop Brain Stimulation and HHO DE MD	
61860	Craniectomy or craniotomy for implantation of neurostimulator electrodes, cerebral, cortical	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1009 Deep Brain Stimulation and HHO-DE-MP- 1131 Responsive Neurostimulation for the Treatment of Refractory Partial Epilepsy	
61863	Twist drill, burr hole, craniotomy, or craniectomy with stereotactic implantation of neurostimulator electrode array in subcortical site (eg, thalamus, globus pallidus, subthalamic nucleus, periventricular, periaqueductal gray), without use of intraoperative microelectrode recording; first array	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1009 Deep Brain Stimulation and HHO-DE-MP- 1131 Responsive Neurostimulation for the Treatment of Refractory Partial Epilepsy	
61864	Twist drill, burr hole, craniotomy, or craniectomy with stereotactic implantation of neurostimulator electrode array in subcortical site (eg, thalamus, globus pallidus, subthalamic nucleus, periventricular, periaqueductal gray), without use of intraoperative microelectrode recording; each additional array (List separately in addition to primary procedure)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1009 Deep Brain Stimulation and HHO-DE-MP- 1131 Responsive Neurostimulation for the Treatment of Refractory Partial Epilepsy	
61867	Twist drill, burr hole, craniotomy, or craniectomy with stereotactic implantation of neurostimulator electrode array in subcortical site (eg, thalamus, globus pallidus, subthalamic nucleus, periventricular, periaqueductal gray), with use of intraoperative microelectrode recording; first array	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1009 Deep Brain Stimulation and HHO-DE-MP- 1131 Responsive Neurostimulation for the Treatment of Refractory Partial Epilepsy	
61868	Twist drill, burr hole, craniotomy, or craniectomy with stereotactic implantation of neurostimulator electrode array in subcortical site (eg, thalamus, globus pallidus, subthalamic nucleus, periventricular, periaqueductal gray), with use of intraoperative microelectrode recording; each additional array (List separately in addition to primary procedure)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1009 Deep Brain Stimulation and HHO-DE-MP- 1131 Responsive Neurostimulation for the Treatment of Refractory Partial Epilepsy	
61880	Revision or removal of intracranial neurostimulator electrodes	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1009 Deep Brain Stimulation and HHO-DE-MP- 1131 Responsive Neurostimulation for the Treatment of Refractory Partial Epilepsy	
61885	Insertion or replacement of cranial neurostimulator pulse generator or receiver, direct or inductive coupling; with connection to a single electrode array	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1009 Deep Brain Stimulation and HHO-DE-MP- 1131 Responsive Neurostimulation for the Treatment of Refractory Partial Epilepsy	
61886	Insertion or replacement of cranial neurostimulator pulse generator or receiver, direct or inductive coupling; with connection to 2 or more electrode arrays	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1009 Deep Brain Stimulation and HHO-DE-MP- 1131 Responsive Neurostimulation for the Treatment of Refractory Partial Epilepsy	
61888	Revision or removal of cranial neurostimulator pulse generator or receiver	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1009 Deep Brain Stimulation and HHO-DE-MP- 1131 Responsive Neurostimulation for the Treatment of Refractory Partial Epilepsy	
61889	Insertion of skull-mounted cranial neurostimulator pulse generator or receiver, including craniectomy or craniotomy, when performed, with direct or inductive coupling, with connection to depth and/or cortical strip electrode array(s)			
62263	Percutaneous lysis of epidural adhesions using solution injection (e.g., hypertonic saline, enzyme) or mechanical means (e.g., catheter) including radiologic localization (includes contrast when administered), multiple adhesiolysis sessions; 2 or more days	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
62264	Percutaneous lysis of epidural adhesions using solution injection (e.g., hypertonic saline, enzyme) or mechanical means (e.g., catheter) including radiologic localization (includes contrast when administered), multiple adhesiolysis sessions; 1 day	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
62280	Injection/infusion of neurolytic substance (e.g., alcohol, phenol, iced saline solutions), with or without other therapeutic substance; subarachnoid	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
62281	Injection/infusion of neurolytic substance (e.g., alcohol, phenol, iced saline solutions), with or without other therapeutic substance; epidural, cervical or thoracic	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
62282	Injection/infusion of neurolytic substance (e.g., alcohol, phenol, iced saline solutions), with or without other therapeutic substance; epidural, lumbar, sacral (caudal)	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
62287	Decompression procedure, percutaneous, of nucleus pulposus of intervertebral disc, any method utilizing needle based technique to remove disc material under fluoroscopic imaging or other form of indirect visualization, with discography and/or epidural injection(s) at the treated level(s), when performed, single or multiple levels, lumbar	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
62292	Injection procedure for chemonucleolysis, including discography, intervertebral disc, single or multiple levels, lumbar	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
62320	Injection(s), of diagnostic or therapeutic substance(s) (e.g., anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, cervical or thoracic; without imaging guidance	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
62321	Injection(s), of diagnostic or therapeutic substance(s) (e.g., anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, cervical or thoracic; with imaging guidance (i.e., fluoroscopy or CT)	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
62322	Injection(s), of diagnostic or therapeutic substance(s) (e.g., anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, interlamina repidural or subarachnoid, lumbar or sacral (caudal); without imaging guidance	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
62323	Injection(s), of diagnostic or therapeutic substance(s) (e.g., anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, lumbar or sacral (caudal); with imaging guidance (i.e., fluoroscopy or CT)	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.

	Injection(s), including indwelling catheter placement, continuous infusion or intermittent		
62324	bolus, of diagnostic or therapeutic substance(s) (e.g., anesthetic, antispasmodic, opioid,	Prior authorization is managed by EviCore.	Prior authorization is managed
02524	steroid, other solution), not including neurolytic substances, interlaminar epidural or	Phot authorization is managed by Evicore.	EviCore.
	subarachnoid, cervical or thoracic; without imaging guidance		
	Injection(s), including indwelling catheter placement, continuous infusion or intermittent		
	bolus, of diagnostic or therapeutic substance(s) (e.g., anesthetic, antispasmodic, opioid,		Prior authorization is managed
62325	steroid, other solution), not including neurolytic substances, interlaminar epidural or	Prior authorization is managed by EviCore.	EviCore.
	subarachnoid, cervical or thoracic; with imaging guidance (i.e., fluoroscopy or CT)		
	Injection(s), including indwelling catheter placement, continuous infusion or intermittent		
			Drier authorization is managed
62326	bolus, of diagnostic or therapeutic substance(s) (e.g., anesthetic, antispasmodic, opioid,	Prior authorization is managed by EviCore.	Prior authorization is managed
	steroid, other solution), not including neurolytic substances, interlaminar epidural or	• ,	EviCore.
	subarachnoid, lumbar or sacral (caudal); without imaging guidance		
	Injection(s), including indwelling catheter placement, continuous infusion or intermittent		
62327	bolus, of diagnostic or therapeutic substance(s) (e.g., anesthetic, antispasmodic, opioid,	Prior authorization is managed by EviCore.	Prior authorization is managed
02327	steroid, other solution), not including neurolytic substances, interlaminar epidural or	Phot authorization is managed by Evicore.	EviCore.
	subarachnoid, lumbar or sacral (caudal); with imaging guidance (i.e., fluoroscopy or CT)		
	Implantation, revision or repositioning of tunneled intrathecal or epidural catheter, for long-		
62350	term medication administration via an external pump or implantable reservoir/infusion	Prior authorization is managed by EviCore.	Prior authorization is managed
02330	pump; without laminectomy	The automation is managed by Evicence.	EviCore.
	Implantation, revision or repositioning of tunneled intrathecal or epidural catheter, for long-		Prior authorization is managed
62351	term medication administration via an external pump or implantable reservoir/infusion	Prior authorization is managed by EviCore.	EviCore.
	pump; with laminectomy		
62360	Implantation or replacement of device for intrathecal or epidural drug infusion;	Prior authorization is managed by EviCore.	Prior authorization is managed
02300	subcutaneous reservoir	Phot authorization is managed by Evicore.	EviCore.
	Implantation or replacement of device for intrathecal or epidural drug infusion;		Prior authorization is managed
62361	nonprogrammable pump	Prior authorization is managed by EviCore.	EviCore.
	Implantation or replacement of device for intrathecal or epidural drug infusion;		Prior authorization is managed
62362		Prior authorization is managed by EviCore.	
	programmable pump, including preparation of pump, with or without programming		EviCore.
	Endoscopic decompression of spinal cord, nerve root(s), including laminotomy, partial		Prior authorization is managed
62380	facetectomy, foraminotomy, discectomy and/or excision of herniated intervertebral disc, 1	Prior authorization is managed by EviCore.	EviCore.
	interspace, lumbar		EVICUIE.
	Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina,		
63001	without facetectomy, foraminotomy or discectomy (e.g., spinal stenosis), 1 or 2 vertebral	Prior authorization is managed by EviCore.	Prior authorization is managed
	segments; cervical		EviCore.
	Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina,		Prior authorization is managed
63005	without facetectomy, foraminotomy	Prior authorization is managed by EviCore.	EviCore.
			Evicore.
	Laminectomy with removal of abnormal facets and/or pars inter- articularis with		Prior authorization is managed
63012	decompression of cauda equina and nerve roots for spondylolisthesis, lumbar (Gill type	Prior authorization is managed by EviCore.	EviCore.
	procedure)		
63015	Laminectomy with exploration and/or decompression of spinal	Prior authorization is managed by EviCore.	Prior authorization is managed
05015	canification and of accompression of spinar	The automation is managed by Evicence.	EviCore.
	Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina,		
63017	without facetectomy, foraminotomy or discectomy (e.g., spinal stenosis), more than 2	Prior authorization is managed by EviCore.	Prior authorization is managed
	vertebral segments; lumbar		EviCore.
	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial		
63020	facetectomy, foraminotomy and/or excision of hemiated intervertebral disc; 1 interspace,	Prior authorization is managed by EviCore.	Prior authorization is managed
05020		Phor authorization is managed by Evicore.	EviCore.
	cervical		
	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial		Prior authorization is managed
63030	facetectomy, foraminotomy and/or excision of herniated intervertebral disc; 1 interspace,	Prior authorization is managed by EviCore.	EviCore.
	lumbar		Evicore.
	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial		
c2027	facetectomy, foraminotomy and/or excision of herniated intervertebral disc; each		Prior authorization is managed
63035	additional interspace, cervical or lumbar (List separately in addition to code for primary	Prior authorization is managed by EviCore.	EviCore.
	procedure)		Encore.
	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial		+ +
63040		Dries authorization is managed by EviCore	Prior authorization is managed
63040	facetectomy, foraminotomy and/or excision of herniated intervertebral disc, reexploration,	Prior authorization is managed by EviCore.	EviCore.
	single interspace; cervical		
	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial		Prior authorization is managed
63042	facetectomy, foraminotomy and/or excision of herniated intervertebral disc, reexploration,	Prior authorization is managed by EviCore.	EviCore.
	single interspace; lumbar		Evicore.
	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial		
	facetectomy, foraminotomy and/or excision of herniated intervertebral disc, reexploration,		Prior authorization is managed
63043	single interspace; each additional cervical interspace (List separately in addition to code for	Prior authorization is managed by EviCore.	EviCore.
	primary procedure)		
	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial		
			Defense and the start of the
	facetectomy, foraminotomy and/or excision of herniated intervertebral disc, reexploration,	Prior authorization is managed by EviCore.	Prior authorization is managed
63044	single interspace; each additional lumbar interspace (List separately in addition to code for		EviCore.
63044			
63044	primary procedure)		
			Deige systhese in the second
63044	primary procedure)	Prior authorization is managed by EviCore.	Prior authorization is managed FviCore

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

	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or			Deine autorization is an and hus
64494	nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; second level (List separately in addition to code for primary procedure)	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
64495	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; third and any additional level(s) (List separately in addition to code for primary procedure)	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
64510	Injection, anesthetic agent; stellate ganglion (cervical sympathetic)	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
64520	Injection, anesthetic agent; lumbar or thoracic (paravertebral sympathetic)	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
64553	Percutaneous implantation of neurostimulator electrode array; cranial nerve	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1238 Electrical Nerve Stimulation	
64566	Posterior tibial neurostimulation, percutaneous needle electrode, single treatment, includes programming	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1237 Posterior Tibial Nerve Stimulation	
64568	Open implantation of cranial nerve (eg, vagus nerve) neurostimulator electrode array and pulse generator	Prior authorization is required for Vagus Nerve Stimulation. Reference policies for additional information.	HHO-DE-MP-1064 Diagnosis and Treatment of Obstructive Sleep Apnea in Adults and HHO-DE-MP-1065 Diagnosis and Treatment of Obstructive Sleep Apnea in Pediatric Individuals	
64569	Revision or replacement of cranial nerve (eg, vagus nerve) neurostimulator electrode array, including connection to existing pulse generator	Prior authorization is required for Vagus Nerve Stimulation. Reference policies for additional information.	HHO-DE-MP-1064 Diagnosis and Treatment of Obstructive Sleep Apnea in Adults and HHO-DE-MP-1065 Diagnosis and Treatment of Obstructive Sleep Apnea in Pediatric Individuals	
64570	Removal of cranial nerve (eg, vagus nerve) neurostimulator electrode array and pulse generator	Prior authorization is required for Vagus Nerve Stimulation. Reference policies for additional information.	HHO-DE-MP-1064 Diagnosis and Treatment of Obstructive Sleep Apnea in Adults	
64575	Open implantation of neurostimulator electrode array; peripheral nerve (excludes sacral	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1238 Electrical Nerve Stimulation	
64580	nerve) Open implantation of neurostimulator electrode array; neuromuscular	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1238 Electrical Nerve Stimulation	
64582	Open implantation of hypoglossal nerve neurostimulator array, pulse generator and distal respiratory sensor electrode or electrode array	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1064 Diagnosis and Treatment of Obstructive Sleep Apnea in Adults and HHO-DE-MP-1065 Diagnosis and Treatment of Obstructive Sleep Apnea in Pediatric Individuals	
64585	Revision or removal of peripheral neurostimulator electrode array	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1238 Electrical Nerve Stimulation	
64590	Insertion or replacement of peripheral, sacral, or gastric neurostimulator pulse generator or receiver, requiring pocket creation and connection between electrode array and pulse generator or receiver	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1235 Gastric Electrical Stimulation and Gastric Pacing	
64595	Revision or removal of peripheral, sacral, or gastric neurostimulator pulse generator or receiver, with detachable connection to electrode array	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1235 Gastric Electrical Stimulation and Gastric Pacing	
64625	Radiofrequency ablation, nerves innervating the sacroiliac joint, with image guidance (ie, fluoroscopy or computed tomography)	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
64633	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); cervical or thoracic, single facet joint	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
64634	Destruction by neurohytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); cervical or thoracic, each additional facet joint (List separately in addition to code for primary procedure)	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
64635	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); lumbar or sacral, single facet joint	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
64636	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); lumbar or sacral, each additional facet joint (List separately in addition to code for primary procedure)	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
64650	Chemodenervation of eccrine glands; both axillae	Prior authorization is required. Reference policies for additional information. DE-MP-1137 Hyperhidrosis		
64653	Chemodenervation of eccrine glands; other area(s) (eg, scalp, face, neck), per day	Prior authorization is required. Reference policies for additional information. DE-MP-1137 Hyperhidrosis		
64670	Removal of cranial nerve (eg, vagus nerve) neurostimulator electrode array and pulse generator	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1064 Diagnosis and Treatment of Obstructive Sleep Apnea in Adults and HHO-DE-MP-1065 Diagnosis and Treatment of Obstructive Sleep Apnea in Pediatric Individuals	
64721	Neuroplasty and/or transposition; median nerve at carpal tunnel	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1038 Carpal Tunnel	
64755	Transection or avulsion of; vagus nerves limited to proximal stomach (selective proximal vagotomy, proximal gastric vagotomy, parietal cell vagotomy, supra- or highly selective vagotomy)	Prior authorization is required.		
64760	Transection or avulsion of; vagus nerve (vagotomy), abdominal	Prior authorization is required.		
64999 65710	Unlisted Procedure: Nervous system Keratoplasty (corneal transplant); anterior lamellar	Prior authorization is required. Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1221 Corneal Transplantation	
65730	Keratoplasty (corneal transplant); anterior lameliar Keratoplasty (corneal transplant); penetrating (except in aphakia or pseudophakia)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1221 Corneal Transplantation	
65750	Keratoplasty (corneal transplant); penetrating (in aphakia)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1221 Corneal Transplantation	1
65755	Keratoplasty (corneal transplant); penetrating (in pseudophakia)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1221 Corneal Transplantation	
65756	Keratoplasty (corneal transplant); endothelial	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1221 Corneal Transplantation	
03750	Backbench preparation of corneal endothelial allograft prior to transplantation (List			

65760				
65760		Prior authorization is required.	HHO-DE-MP-1099 Corneal Surgery to Correct Refractive Errors,	
	Keratomileusis	Reference policies for additional information.	Phototherapeutic Keratectomy and Corneal Collagen Cross-	
			Linking Surgery	
		Prior authorization is required.	HHO-DE-MP-1099 Corneal Surgery to Correct Refractive Errors,	
65365				
65765	Keratophakia	Reference policies for additional information.	Phototherapeutic Keratectomy and Corneal Collagen Cross-	
			Linking Surgery	
		Prior authorization is required.	HHO-DE-MP-1099 Corneal Surgery to Correct Refractive Errors,	
65767	Epikeratoplasty	Reference policies for additional information.	Phototherapeutic Keratectomy and Corneal Collagen Cross-	
	_p,		Linking Surgery	
65770	Keratoprosthesis	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1221 Corneal Transplantation	
		Prior authorization is required.	HHO-DE-MP-1099 Corneal Surgery to Correct Refractive Errors,	
65771	Radial keratotomy	Reference policies for additional information.	Phototherapeutic Keratectomy and Corneal Collagen Cross-	
	,		Linking Surgery	
65780	Ocular surface reconstruction: amniotic membrane transplantation, multiple layers	Prior authorization is required.	ching surgery	
66174	Transluminal dilation of aqueous outflow canal; without retention of device or stent	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1024 Aqueous Shunts and Stents for Glaucoma	
66175	Transluminal dilation of aqueous outflow canal; with retention of device or stent	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1024 Aqueous Shunts and Stents for Glaucoma	
	Insertion of anterior segment aqueous drainage device, without extraocular reservoir,			
66183	external approach	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1024 Aqueous Shunts and Stents for Glaucoma	
	Extrascapular cataract removal with insertion of intraocular lens prosthesis (1 stage			
	procedure), manual or mechanical technique (e.g., irrigation and aspiration or			
	phacoemulsification), complex, requiring devices or techniques not generally used in			1
66989	routine cataract surgery (e.g., iris expansion device, suture support for intraocular lens, or	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1024 Aqueous Shunts and Stents for Glaucoma	
	primary posterior capsulorrhexis) or performed on patients in the amblyogenic			
	developmental stage; with insertion of intraocular (e.g., trabecular meshwork, supraciliary,			1
	suprachoroidal) anterior segment aqueous drainage			
	Extrascapular cataract removal with insertion of intraocular lens prosthesis (1 stage			
	procedure), manual or mechanical technique (e.g., irrigation and aspiration or			
66991	phacoemulsification); with insertion of intraocular (e.g., trabecular meshwork, supraciliary,	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1024 Aqueous Shunts and Stents for Glaucoma	
	suprachoroidal) anterior segment aqueous drainage device, without extraocular reservoir,			
	internal approach, one or more			
66999	Unlisted procedure, anterior segment of eye	Prior authorization is required.		
67299	Unlisted procedure, prosterior segment	Prior authorization is required.		
67399	Unlisted procedure, extraocular muscle	Prior authorization is required.		
67599	Unlisted procedure, orbit	Prior authorization is required.		
67999	Unlisted procedure: Eyelid	Prior authorization is required.		
68399	Procedure: Conjunctiva (eye)	Prior authorization is required.		
69399	Procedure: External ear	Prior authorization is required.		
		Prior authorization is required. Reference policies for additional information. DE-MP-1137		
69676	Tympanic neurectomy			
		Hyperhidrosis		
			HHO-DE-MP-1190 External Hearing Aids, Auditory Brainstem	
	Implantation, osseointegrated implant, skull: with percutaneous attachment to external			
69714	Implantation, osseointegrated implant, skull; with percutaneous attachment to external	Prior authorization is required. Reference policies for additional information.	Implant, Bone-Anchored Hearing Devices and Audiological	
69714	Implantation, osseointegrated implant, skull; with percutaneous attachment to external speech processor	Prior authorization is required. Reference policies for additional information.	Implant, Bone-Anchored Hearing Devices and Audiological Testing	
	speech processor			
69799	speech processor Unlisted procedure, middle ear	Prior authorization is required.	Testing	
	speech processor	Prior authorization is required. Prior authorization is required. Reference policies for additional information and for medical		
69799 69930	speech processor Unlisted procedure, middle ear Cochlear device implantation, with or without mastoidectomy	Prior authorization is required. Prior authorization is required. Reference policies for additional information and for medical necessity criteria.	Testing	
69799 69930 69949	speech processor Unlisted procedure, middle ear Cochlear device implantation, with or without mastoidectomy Unlisted procedure, inner ear	Prior authorization is required. Prior authorization is required. Reference policies for additional information and for medical necessity criteria. Prior authorization is required.	Testing	
69799 69930	speech processor Unlisted procedure, middle ear Cochlear device implantation, with or without mastoidectomy	Prior authorization is required. Prior authorization is required. Reference policies for additional information and for medical necessity criteria. Prior authorization is required. Prior authorization is required.	Testing	
69799 69930 69949 69979	speech processor Unlisted procedure, middle ear Cochlear device implantation, with or without mastoidectomy Unlisted procedure, inner ear Unlisted procedure, temporal bone, middle fossa approach	Prior authorization is required. Prior authorization is required. Reference policies for additional information and for medical necessity criteria. Prior authorization is required.	Testing HHO-DE-MP-1145 Cochlear Implants	
69799 69930 69949	speech processor Unlisted procedure, middle ear Cochlear device implantation, with or without mastoidectomy Unlisted procedure, inner ear	Prior authorization is required. Prior authorization is required. Reference policies for additional information and for medical necessity criteria. Prior authorization is required. Prior authorization is required. Prior authorization is required for billed charges greater than \$500. Reference policies for	Testing	
69799 69930 69949 69979 70250	speech processor Unlisted procedure, middle ear Cochlear device implantation, with or without mastoidectomy Unlisted procedure, inner ear Unlisted procedure, temporal bone, middle fossa approach X-ray of skull, fewer than 4 views	Prior authorization is required. Prior authorization is required. Reference policies for additional information and for medical necessity criteria. Prior authorization is required. Prior authorization is required. Prior authorization is required charges greater than \$500. Reference policies for additional information.	Testing HHO-DE-MP-1145 Cochlear Implants HHO-DE-MP-1136 Temporomandibular Joint Dysfunction	
69799 69930 69949 69979	speech processor Unlisted procedure, middle ear Cochlear device implantation, with or without mastoidectomy Unlisted procedure, inner ear Unlisted procedure, temporal bone, middle fossa approach	Prior authorization is required. Prior authorization is required. Reference policies for additional information and for medical necessity criteria. Prior authorization is required. Prior authorization is required. Prior authorization is required charges greater than \$500. Reference policies for additional information. Prior authorization is required for billed charges greater than \$500. Reference policies for	Testing HHO-DE-MP-1145 Cochlear Implants	
69799 69930 69949 69979 70250 70260	speech processor Unlisted procedure, middle ear Cochlear device implantation, with or without mastoidectomy Unlisted procedure, inner ear Unlisted procedure, temporal bone, middle fossa approach X-ray of skull, fewer than 4 views Radiologic examination, skull; complete, minimum of 4 views	Prior authorization is required. Prior authorization is required. Prior authorization is required. Reference policies for additional information and for medical necessity criteria. Prior authorization is required. Prior authorization is required. Prior authorization is required for billed charges greater than \$500. Reference policies for additional information. Prior authorization is required for billed charges greater than \$500. Reference policies for additional information.	Testing HHO-DE-MP-1145 Cochlear Implants HHO-DE-MP-1136 Temporomandibular Joint Dysfunction HHO-DE-MP-1136 Temporomandibular Joint Dysfunction	
69799 69930 69949 69979 70250	speech processor Unlisted procedure, middle ear Cochlear device implantation, with or without mastoidectomy Unlisted procedure, inner ear Unlisted procedure, temporal bone, middle fossa approach X-ray of skull, fewer than 4 views	Prior authorization is required. Prior authorization is required. Reference policies for additional information and for medical necessity criteria. Prior authorization is required. Prior authorization is required. Prior authorization is required charges greater than \$500. Reference policies for additional information. Prior authorization is required for billed charges greater than \$500. Reference policies for	Testing HHO-DE-MP-1145 Cochlear Implants HHO-DE-MP-1136 Temporomandibular Joint Dysfunction	
69799 69930 69949 69979 70250 70260 70332	speech processor Unlisted procedure, middle ear Cochlear device implantation, with or without mastoidectomy Unlisted procedure, inner ear Unlisted procedure, temporal bone, middle fossa approach X-ray of skull, fewer than 4 views Radiologic examination, skull; complete, minimum of 4 views Temporomandibular joint arthrography, radiological supervision and interpretation	Prior authorization is required. Prior authorization is required. Prior authorization is required. Reference policies for additional information and for medical necessity criteria. Prior authorization is required. Prior authorization is required. Prior authorization is required. Prior authorization is required for billed charges greater than \$500. Reference policies for additional information. Prior authorization is required. Reference policies for additional information. Prior authorization is required. Reference policies for additional information. Prior authorization is required. Prio	Testing HHO-DE-MP-1145 Cochlear Implants HHO-DE-MP-1136 Temporomandibular Joint Dysfunction HHO-DE-MP-1136 Temporomandibular Joint Dysfunction HHO-DE-MP-1136 Temporomandibular Joint Dysfunction	Prior authorization is managed by
69799 69930 69949 69979 70250 70260	speech processor Unlisted procedure, middle ear Cochlear device implantation, with or without mastoidectomy Unlisted procedure, inner ear Unlisted procedure, temporal bone, middle fossa approach X-ray of skull, fewer than 4 views Radiologic examination, skull; complete, minimum of 4 views	Prior authorization is required. Prior authorization is required. Prior authorization is required. Reference policies for additional information and for medical necessity criteria. Prior authorization is required. Prior authorization is required. Prior authorization is required for billed charges greater than \$500. Reference policies for additional information. Prior authorization is required for billed charges greater than \$500. Reference policies for additional information.	Testing HHO-DE-MP-1145 Cochlear Implants HHO-DE-MP-1136 Temporomandibular Joint Dysfunction HHO-DE-MP-1136 Temporomandibular Joint Dysfunction	
69799 69930 69949 69979 70250 70260 70332 70336	speech processor Unlisted procedure, middle ear Cochlear device implantation, with or without mastoidectorny Unlisted procedure, inner ear Unlisted procedure, temporal bone, middle fossa approach X-ray of skull, fewer than 4 views Radiologic examination, skull; complete, minimum of 4 views Temporomandibular joint arthrography, radiological supervision and interpretation Magnetic resonance (eg, proton) imaging, temporomandibular joint(s)	Prior authorization is required. Prior authorization is required. Reference policies for additional information and for medical necessity criteria. Prior authorization is required. Prior authorization is required for billed charges greater than \$500. Reference policies for additional information. Prior authorization is required. Reference policies for additional information. Prior authorization is required. Reference policies for additional information. Prior authorization is required. Reference policies for additional information. Prior authorization is prequired. Reference policies for additional information.	Testing HHO-DE-MP-1145 Cochlear Implants HHO-DE-MP-1136 Temporomandibular Joint Dysfunction HHO-DE-MP-1136 Temporomandibular Joint Dysfunction HHO-DE-MP-1136 Temporomandibular Joint Dysfunction HHO-DE-MP-1136 Temporomandibular Joint Dysfunction	Prior authorization is managed by EviCore.
69799 69930 69949 69979 70250 70260 70332 70336 70350	speech processor Unlisted procedure, middle ear Cochlear device implantation, with or without mastoidectomy Unlisted procedure, inner ear Unlisted procedure, temporal bone, middle fossa approach X-ray of skull, fewer than 4 views Radiologic examination, skull; complete, minimum of 4 views Temporomandibular joint arthrography, radiological supervision and interpretation Magnetic resonance (eg, proton) imaging, temporomandibular joint(s) Cephalogram, orthodontic	Prior authorization is required. Prior authorization is required. Reference policies for additional information and for medical necessity criteria. Prior authorization is required. Prior authorization is required for billed charges greater than \$500. Reference policies for additional information. Prior authorization is required for billed charges greater than \$500. Reference policies for additional information. Prior authorization is required. Reference policies for additional information. Prior authorization is required. Reference policies for additional information. Prior authorization is required. Reference policies for additional information. Prior authorization is required. Reference policies for additional information. Prior authorization is required. Reference policies for additional information.	Testing HHO-DE-MP-1145 Cochlear Implants HHO-DE-MP-1136 Temporomandibular Joint Dysfunction HHO-DE-MP-1136 Temporomandibular Joint Dysfunction HHO-DE-MP-1136 Temporomandibular Joint Dysfunction HHO-DE-MP-1136 Temporomandibular Joint Dysfunction	
69799 69930 69949 69979 70250 70260 70332 70336	speech processor Unlisted procedure, middle ear Cochlear device implantation, with or without mastoidectorny Unlisted procedure, inner ear Unlisted procedure, temporal bone, middle fossa approach X-ray of skull, fewer than 4 views Radiologic examination, skull; complete, minimum of 4 views Temporomandibular joint arthrography, radiological supervision and interpretation Magnetic resonance (eg, proton) imaging, temporomandibular joint(s)	Prior authorization is required. Prior authorization is required. Reference policies for additional information and for medical necessity criteria. Prior authorization is required. Prior authorization is required for billed charges greater than \$500. Reference policies for additional information. Prior authorization is required. Reference policies for additional information. Prior authorization is required. Reference policies for additional information. Prior authorization is required. Reference policies for additional information. Prior authorization is prequired. Reference policies for additional information.	Testing HHO-DE-MP-1145 Cochlear Implants HHO-DE-MP-1136 Temporomandibular Joint Dysfunction HHO-DE-MP-1136 Temporomandibular Joint Dysfunction HHO-DE-MP-1136 Temporomandibular Joint Dysfunction HHO-DE-MP-1136 Temporomandibular Joint Dysfunction	EviCore.
69799 69930 69949 69979 70250 70260 70332 70336 70350 70355	speech processor Unlisted procedure, middle ear Cochlear device implantation, with or without mastoidectomy Unlisted procedure, inner ear Unlisted procedure, temporal bone, middle fossa approach X-ray of skull, fewer than 4 views Radiologic examination, skull; complete, minimum of 4 views Temporomandibular joint arthrography, radiological supervision and interpretation Magnetic resonance (eg, proton) imaging, temporomandibular joint(s) Cephalogram, orthodontic Orthopantogram (eg, panoramic x-ray)	Prior authorization is required. Prior authorization is required. Reference policies for additional information and for medical necessity criteria. Prior authorization is required. Prior authorization is required for billed charges greater than \$500. Reference policies for additional information. Prior authorization is required for billed charges greater than \$500. Reference policies for additional information. Prior authorization is required. Reference policies for additional information. Prior authorization is required. Reference policies for additional information. Prior authorization is required. Reference policies for additional information. Prior authorization is required. Reference policies for additional information. Prior authorization is required. Reference policies for additional information. Prior authorization is required. Reference policies for additional information. Prior authorization is required. Reference policies for additional information.	Testing HHO-DE-MP-1145 Cochlear Implants HHO-DE-MP-1136 Temporomandibular Joint Dysfunction HHO-DE-MP-1136 Temporomandibular Joint Dysfunction HHO-DE-MP-1136 Temporomandibular Joint Dysfunction HHO-DE-MP-1136 Temporomandibular Joint Dysfunction	EviCore. Prior authorization is managed by
69799 69930 69949 69979 70250 70260 70332 70336 70350	speech processor Unlisted procedure, middle ear Cochlear device implantation, with or without mastoidectomy Unlisted procedure, inner ear Unlisted procedure, temporal bone, middle fossa approach X-ray of skull, fewer than 4 views Radiologic examination, skull; complete, minimum of 4 views Temporomandibular joint arthrography, radiological supervision and interpretation Magnetic resonance (eg, proton) imaging, temporomandibular joint(s) Cephalogram, orthodontic	Prior authorization is required. Prior authorization is required. Reference policies for additional information and for medical necessity criteria. Prior authorization is required. Prior authorization is required for billed charges greater than \$500. Reference policies for additional information. Prior authorization is required for billed charges greater than \$500. Reference policies for additional information. Prior authorization is required. Reference policies for additional information. Prior authorization is required. Reference policies for additional information. Prior authorization is required. Reference policies for additional information. Prior authorization is required. Reference policies for additional information. Prior authorization is required. Reference policies for additional information.	Testing HHO-DE-MP-1145 Cochlear Implants HHO-DE-MP-1136 Temporomandibular Joint Dysfunction HHO-DE-MP-1136 Temporomandibular Joint Dysfunction HHO-DE-MP-1136 Temporomandibular Joint Dysfunction HHO-DE-MP-1136 Temporomandibular Joint Dysfunction	EviCore.
69799 69930 69949 69979 70250 70260 70332 70336 70336 70355 70450	speech processor Unlisted procedure, middle ear Cochlear device implantation, with or without mastoidectomy Unlisted procedure, inner ear Unlisted procedure, temporal bone, middle fossa approach X-ray of skull, fewer than 4 views Radiologic examination, skull; complete, minimum of 4 views Temporomandibular joint arthrography, radiological supervision and interpretation Magnetic resonance (eg, proton) imaging, temporomandibular joint(s) Cephalogram, orthodontic Orthopantogram (eg, panoramic x-ray) C T Head Without Contrast	Prior authorization is required. Prior authorization is required for billed charges greater than \$500. Reference policies for additional information. Prior authorization is required. Reference policies for additional information. Prior authorization is required. Reference policies for additional information. Prior authorization is required. Reference policies for additional information. Prior authorization is required. Reference policies for additional information. Prior authorization is required. Reference policies for additional information. Prior authorization is required. Reference policies for additional information. Prior authorization is required. Reference policies for additional information. Prior authorization is required.	Testing HHO-DE-MP-1145 Cochlear Implants HHO-DE-MP-1136 Temporomandibular Joint Dysfunction HHO-DE-MP-1136 Temporomandibular Joint Dysfunction HHO-DE-MP-1136 Temporomandibular Joint Dysfunction HHO-DE-MP-1136 Temporomandibular Joint Dysfunction	EviCore. Prior authorization is managed by EviCore.
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69799 69930 69949 69979 70250 70260 70332 70336 70350 70355 70450 70450 70460 70470	speech processor Unlisted procedure, middle ear Cochlear device implantation, with or without mastoidectomy Unlisted procedure, inner ear Unlisted procedure, temporal bone, middle fossa approach X-ray of skull, fewer than 4 views Radiologic examination, skull; complete, minimum of 4 views Temporomandibular joint arthrography, radiological supervision and interpretation Magnetic resonance (eg, proton) imaging, temporomandibular joint(s) Cephalogram, orthodontic Orthopantogram (eg, panoramic x-ray) C T Head Without Contrast C T Head With Contrast	Prior authorization is required. Prior authorization is required for billed charges greater than \$500. Reference policies for additional information. Prior authorization is required. Reference policies for additional information. Prior authorization is required. Reference policies for additional information. Prior authorization is required. Reference policies for additional information. Prior authorization is required. Reference policies for additional information. Prior authorization is required. Reference policies for additional information. Prior authorization is managed by EviCore. Prior authorization is managed by EviCore. Prior authorization is managed by EviCore.	Testing HHO-DE-MP-1145 Cochlear Implants HHO-DE-MP-1136 Temporomandibular Joint Dysfunction HHO-DE-MP-1136 Temporomandibular Joint Dysfunction HHO-DE-MP-1136 Temporomandibular Joint Dysfunction HHO-DE-MP-1136 Temporomandibular Joint Dysfunction	EviCore. Prior authorization is managed by EviCore. Prior authorization is managed by EviCore. Prior authorization is managed by EviCore. Prior authorization is managed by EviCore.
69799 69930 69949 69979 70250 70260 70332 70336 70350 70355 70450 70450 70460 70470 70480	speech processor Unlisted procedure, middle ear Cochlear device implantation, with or without mastoidectomy Unlisted procedure, inner ear Unlisted procedure, temporal bone, middle fossa approach X-ray of skull, fewer than 4 views Radiologic examination, skull; complete, minimum of 4 views Temporomandibular joint arthrography, radiological supervision and interpretation Magnetic resonance (eg, proton) imaging, temporomandibular joint(s) Cephalogram, orthodontic Orthopantogram (eg, panoramic x-ray) C T Head Without Contrast C T Head With Contrast C T Head Without Contrast C T Orbit Without Contrast	Prior authorization is required. Prior authorization is required. Reference policies for additional information and for medical necessity criteria. Prior authorization is required. Prior authorization is required for billed charges greater than \$500. Reference policies for additional information. Prior authorization is required. Reference policies for additional information. Prior authorization is required. Reference policies for additional information. Prior authorization is required. Reference policies for additional information. Prior authorization is required. Reference policies for additional information. Prior authorization is required. Reference policies for additional information. Prior authorization is required. Reference policies for additional information. Prior authorization is required. Reference policies for additional information. Prior authorization is managed by EviCore.	Testing HHO-DE-MP-1145 Cochlear Implants HHO-DE-MP-1136 Temporomandibular Joint Dysfunction HHO-DE-MP-1136 Temporomandibular Joint Dysfunction HHO-DE-MP-1136 Temporomandibular Joint Dysfunction HHO-DE-MP-1136 Temporomandibular Joint Dysfunction	EviCore. Prior authorization is managed by EviCore. Prior authorization is managed by EviCore. Prior authorization is managed by EviCore. Prior authorization is managed by EviCore. Prior authorization is managed by
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69799 69930 69949 69979 70250 70260 70332 70336 70350 70355 70450 70450 70460 70460 70470 70480 70481	speech processor Unlisted procedure, middle ear Cochlear device implantation, with or without mastoidectomy Unlisted procedure, inner ear Unlisted procedure, temporal bone, middle fossa approach X-ray of skull, fewer than 4 views Radiologic examination, skull; complete, minimum of 4 views Temporomandibular joint arthrography, radiological supervision and interpretation Magnetic resonance (eg, proton) imaging, temporomandibular joint(s) Cephalogram, orthodontic Orthopantogram (eg, panoramic x-ray) C T Head Without Contrast C T Head With Contrast C T Head With Contrast C T Orbit With Contrast C T Orbit With Contrast	Prior authorization is required. Prior authorization is required. Reference policies for additional information and for medical necessity criteria. Prior authorization is required. Prior authorization is required for billed charges greater than \$500. Reference policies for additional information. Prior authorization is required. Charges greater than \$500. Reference policies for additional information. Prior authorization is required. Reference policies for additional information. Prior authorization is required. Reference policies for additional information. Prior authorization is required. Reference policies for additional information. Prior authorization is required. Reference policies for additional information. Prior authorization is required. Reference policies for additional information. Prior authorization is required. Reference policies for additional information. Prior authorization is managed by EviCore.	Testing HHO-DE-MP-1145 Cochlear Implants HHO-DE-MP-1136 Temporomandibular Joint Dysfunction HHO-DE-MP-1136 Temporomandibular Joint Dysfunction HHO-DE-MP-1136 Temporomandibular Joint Dysfunction HHO-DE-MP-1136 Temporomandibular Joint Dysfunction	EviCore. Prior authorization is managed by EviCore. Prior authorization is managed by

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

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

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

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74176	CT Abdomen And Pelvis Without Contrast	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
74177	CT Abdomen And Pelvis With Contrast	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
74178	Computed Tomography, Abdomen And Pelvis; Without Contrast Material In One Or Both Body Regions, Followed By Contrast Material(S) And Further Sections In One Or Both Body Regions	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
74181	M R I Abdomen Without Contrast	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
74182	M R I Abdomen With Contrast	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
74183	M R I Abdomen With & Without Contrast	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
74185	M R A Abdomen With Or Without Contrast	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
74261	Computed tomographic (CT) colonography, diagnostic, including image postprocessing; without contrast material	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
74262	Computed tomographic (CT) colonography, diagnostic, including image postprocessing; with contrast material(s) including non-contrast images, if performed	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
74263	Computed tomographic (CT) colonography, screening, including image postprocessing	Prior authorization is managed by EviCore. For members under age 45. Reference policies for additional information.	HHO-DE-MP-1007 Colorectal Cancer Screening	Prior authorization is managed by EviCore.
74280	Radiologic examination, colon, including scout abdominal radiograph(s) and delayed image(s), when performed; double-contrast (eg, high density barium and air) study, including glucagon, when administered	Prior authorization is required for members under the age of 45. Reference policies for additional information.	HHO-DE-MP-1007 Colorectal Cancer Screening	
74712	Magnetic resonance (eg, proton) imaging, fetal, including placental and maternal pelvic imaging when performed; single or first gestation	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
74713	Magnetic resonance (eg, proton) imaging, fetal, including placental and maternal pelvic imaging when performed; each additional gestation (List separately in addition to code for primary procedure)	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
75557	Cardiac magnetic resonance imaging for morphology and function without contrast material	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
75559	Cardiac magnetic resonance imaging for morphology and function without contrast material; with stress imaging	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
75561	Cardiac magnetic resonance imaging for morphology and function without contrast material(s), followed by contrast material(s) and further sequences	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
75563	Cardiac magnetic resonance imaging for morphology and function without contrast material(s), followed by contrast material(s) and further sequences; with stress imaging	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
75565	Cardiac magnetic resonance imaging for velocity flow mapping (list separately in addition to code for primary procedure)	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
75571	Computed tomography, heart, without contrast material, with quantitative evaluation of coronary calcium	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
75572	Computed tomography, heart, with contrast material, for evaluation of cardiac structure and morphology (including 3d image postprocessing, assessment of cardiac function and evaluation of venous structures, if performed)	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
75573	Computed tomography, heart, with contrast material, for evaluation of cardiac structure and morphology in the setting of congenital heart disease (including 3D image postprocessing, assessment of left ventricular [LV] cardiac function, right ventricular [RV] structure and function and evaluation of vascular structures, if performed)	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
75574	Computed tomographic angiography, heart, coronary arteries and bypass grafts (when present), with contrast material, including 3d image postprocessing (including evaluation of cardiac structure and morphology, assessment of cardiac function and evaluation of venous structures, if performed)	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
75580	Noninvasive estimate of coronary fractional flow reserve (FFR) derived from augmentative software analysis of the data set from a coronary computed tomography angiography, with interpretation and report by a physician or other qualified health care professional	Prior authorization is managed by EviCore.		Prior authorization is managed b EviCore.
75635	CT Angiography Abdominal Aorta	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
75894	Transcatheter therapy, embolization, any method, radiological supervision and interpretation	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1156 Treatment of Abnormal Uterine Bleeding and Fibroids	
75956	Endovascular repair of descending thoracic aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption); involving coverage of left subclavian artery origin, initial endoprosthesis plus descending thoracic aortic extension(s), if required, to level of celiac artery origin, radiological supervision and interpretation	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1157 Endovascular/Endoluminal Stent Grafts	
75957	Endovascular repair of descending thoracic aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption); not involving coverage of left subclavian artery origin, initial endoprosthesis plus descending thoracic aortic extension(s), if required, to level of celica artery origin, radiological supervision and interpretation	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1157 Endovascular/Endoluminal Stent Grafts	

75958	Placement of proximal extension prosthesis for endovascular repair of descending thoracic aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption), radiological supervision and interpretation	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1157 Endovascular/Endoluminal Stent Grafts	
75959	Placement of distal extension prosthesis(s) (delayed) after endovascular repair of descending thoracic aorta, as needed, to level of celiac origin, radiological supervision and interpretation	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1157 Endovascular/Endoluminal Stent Grafts	
76376	3D Rendering W/O Postprocessing	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
76377	3D Rendering W Postprocessing	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
76380	CT Limited Or Localized Follow-Up Study	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
76390	M R I Spectroscopy	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
76391	Magnetic resonance (eg, vibration) elastography	Prior authorization is managed by EviCore.		Prior authorization is managed b EviCore.
76496	Unlisted fluoroscopic procedure (eg, diagnostic, interventional)	Prior authorization is required.		
76497	Unlisted computed tomography procedure (eg, diagnostic, interventional)	Prior authorization is required.		
76498	Unlisted magnetic resonance procedure (eg, diagnostic, interventional)	Prior authorization is required.		
76499	Unlisted diagnostic radiographic procedure	Prior authorization is required for not otherwise classified codes.		
76536	Ultrasound, soft tissues of head and neck (eg, thyroid, parathyroid, parotid), real time with image documentation	Prior authorization is required for billed charges greater than \$500. Reference policies for additional information.	HHO-DE-MP-1136 Temporomandibular Joint Dysfunction	
76706	Ultrasound, abdominal aorta, real time with image documentation, screening study for abdominal aortic aneurysm (AAA)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1157 Endovascular/Endoluminal Stent Grafts	
76882	Ultrasound, extremity, nonvascular, real-time with image documentation; limited, anatomic specific	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1253 Ultrasound Guidance for Joint, Tendon, Tendon Sheath and Trigger Point Injections	
76942	Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision and interpretation	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1100 Surgical Treatment of Varicose Veins and HHO-DE-MP-1253 Ultrasound Guidance for Joint, Tendon, Tendon Sheath and Trigger Point Injections	
76977	Ultrasound bone density measurement and interpretation, peripheral site(s), any method	Prior authorization is required.		
76998	Ultrasonic guidance, intraoperative	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1100 Surgical Treatment of Varicose Veins	
76999	Unlisted ultrasound procedure (eg, diagnostic, interventional)	Prior authorization is required for not otherwise classified codes.		
77021	M R I Guidance For Needle Placement	Prior authorization is managed by EviCore.		Prior authorization is managed b EviCore.
77022	Magnetic resonance imaging guidance for and monitoring of, parenchymal tissue ablation	Prior authorization is required and managed by EviCore. Reference policies for additional information.	HHO-DE-MP-1156 Treatment of Abnormal Uterine Bleeding and Fibroids	Prior authorization is managed b EviCore.
77046	Magnetic resonance imaging, breast, without contrast material; unilateral	Prior authorization is managed by EviCore.		Prior authorization is managed b EviCore.
77047	Magnetic resonance imaging, breast, without contrast material; bilateral	Prior authorization is managed by EviCore.		Prior authorization is managed b EviCore.
77048	Magnetic resonance imaging, breast, without and with contrast material(s), including computer-aided detection (CAD real-time lesion detection, characterization and pharmacokinetic analysis), when performed; unilateral	Prior authorization is managed by EviCore.		Prior authorization is managed b EviCore.
77049	Magnetic resonance imaging, breast, without and with contrast material(s), including computer-aided detection (CAD real-time lesion detection, characterization and	Prior authorization is managed by EviCore.		
	pharmacokinetic analysis), when performed; bilateral	······································		Prior authorization is managed b EviCore.
77078	pharmacokinetic analysis), when performed; bilateral Computed tomography, bone mineral density study, 1 or more sites, axial skeleton (eg, hips, pelvis, spine)	Prior authorization is required and managed by EviCore. Reference policies for additional information.	HHO-DE-MP-1105 Bone Mineral Density Studies	EviCore.
77084	Computed tomography, bone mineral density study, 1 or more sites, axial skeleton (eg,	Prior authorization is required and managed by EviCore.	HHO-DE-MP-1105 Bone Mineral Density Studies	EviCore. Prior authorization is managed b EviCore.
	Computed tomography, bone mineral density study, 1 or more sites, axial skeleton (eg, hips, pelvis, spine)	Prior authorization is required and managed by EviCore. Reference policies for additional information.	HHO-DE-MP-1105 Bone Mineral Density Studies	EviCore. Prior authorization is managed b EviCore. Prior authorization is managed b
77084	Computed tomography, bone mineral density study, 1 or more sites, axial skeleton (eg, hips, pelvis, spine) Magnetic resonance (eg, proton) imaging, bone marrow blood supply	Prior authorization is required and managed by EviCore. Reference policies for additional information. Prior authorization is managed by EviCore.	HHO-DE-MP-1105 Bone Mineral Density Studies	Prior authorization is managed b EviCore. Prior authorization is managed b
77084 77299	Computed tomography, bone mineral density study, 1 or more sites, axial skeleton (eg, hips, pelvis, spine) Magnetic resonance (eg, proton) imaging, bone marrow blood supply Unlisted procedure, therapeutic radiology clinical treatment planning Radiation treatment delivery, stereotactic radiosurgery (SRS), complete course of	Prior authorization is required and managed by EviCore. Reference policies for additional information. Prior authorization is managed by EviCore. Prior authorization is required.	HHO-DE-MP-1105 Bone Mineral Density Studies	EviCore. Prior authorization is managed b EviCore. Prior authorization is managed b
77084 77299 77371	Computed tomography, bone mineral density study, 1 or more sites, axial skeleton (eg, hips, pelvis, spine) Magnetic resonance (eg, proton) imaging, bone marrow blood supply Unlisted procedure, therapeutic radiology clinical treatment planning Radiation treatment delivery, stereotactic radiosurgery (SRS), complete course of treatment of cranial lesion(s) consisting of 1 session; multi-source CobaHio 60 based Radiation treatment delivery, stereotactic radiosurgery (SRS), complete course of	Prior authorization is required and managed by EviCore. Reference policies for additional information. Prior authorization is managed by EviCore. Prior authorization is required. Prior authorization is required for conditions other than cancer.	HHO-DE-MP-1105 Bone Mineral Density Studies	EviCore. Prior authorization is managed b EviCore. Prior authorization is managed b
77084 77299 77371 77372	Computed tomography, bone mineral density study, 1 or more sites, axial skeleton (eg, hips, pelvis, spine) Magnetic resonance (eg, proton) imaging, bone marrow blood supply Unlisted procedure, therapeutic radiology clinical treatment planning Radiation treatment delivery, stereotactic radiosurgery (SRS), complete course of treatment of cranial lesion(s) consisting of 1 session; multi-source Cobalt 60 based Radiation treatment delivery, stereotactic radiosurgery (SRS), complete course of treatment of cranial lesion(s) consisting of 1 session; linear accelerator based Stereotactic body radiation therapy, treatment delivery, per fraction to 1 or more lesions, including image guidance, entire course not to exceed 5 fractions Intensity modulated radiation treatment delivery (IMRT), includes guidance and tracking, when performed; simple	Prior authorization is required and managed by EviCore. Reference policies for additional information. Prior authorization is managed by EviCore. Prior authorization is required. Prior authorization is required for conditions other than cancer. Prior authorization is required for conditions other than cancer.	HHO-DE-MP-1105 Bone Mineral Density Studies	EviCore. Prior authorization is managed b EviCore. Prior authorization is managed b
77084 77299 77371 77372 77373	Computed tomography, bone mineral density study, 1 or more sites, axial skeleton (eg, hips, pelvis, spine) Magnetic resonance (eg, proton) imaging, bone marrow blood supply Unlisted procedure, therapeutic radiology clinical treatment planning Radiation treatment delivery, stereotactic radiosurgery (SRS), complete course of treatment of cranial lesion(s) consisting of 1 session; multi-source Cobalt 60 based Radiation treatment delivery, stereotactic radiosurgery (SRS), complete course of treatment of cranial lesion(s) consisting of 1 session; linear accelerator based Stereotactic body radiation therapy, treatment delivery, per fraction to 1 or more lesions, including image guidance, entire course not to exceed 5 fractions Intensity modulated radiation treatment delivery (IMRT), includes guidance and tracking, when performed; simple Intensity modulated radiation treatment delivery (IMRT), includes guidance and tracking, when performed; complex	Prior authorization is required and managed by EviCore. Reference policies for additional information. Prior authorization is managed by EviCore. Prior authorization is required. Prior authorization is required for conditions other than cancer. Prior authorization is required for conditions other than cancer. Prior authorization is required for conditions other than cancer.	HHO-DE-MP-1105 Bone Mineral Density Studies	EviCore. Prior authorization is managed b EviCore. Prior authorization is managed b
77084 77299 77371 77372 77373 77373 77385	Computed tomography, bone mineral density study, 1 or more sites, axial skeleton (eg, hips, pelvis, spine) Magnetic resonance (eg, proton) imaging, bone marrow blood supply Unlisted procedure, therapeutic radiology clinical treatment planning Radiation treatment delivery, stereotactic radiosurgery (SRS), complete course of treatment of cranial lesion(s) consisting of 1 session; multi-source Cobalt 60 based Radiation treatment delivery, stereotactic radiosurgery (SRS), complete course of treatment of cranial lesion(s) consisting of 1 session; incluidant the stereot of treatment delivery, stereotactic radiosurgery (SRS), complete course of treatment of cranial lesion(s) consisting of 1 session; linear accelerator based Stereotactic body radiation therapy, treatment delivery, per fraction to 1 or more lesions, including image guidance, entire course not to exceed 5 fractions Intensity modulated radiation treatment delivery (IMRT), includes guidance and tracking, when performed; simple Intensity modulated radiation treatment delivery (IMRT), includes guidance and tracking, when performed; simple	Prior authorization is required and managed by EviCore. Reference policies for additional information. Prior authorization is managed by EviCore. Prior authorization is required. Prior authorization is required for conditions other than cancer. Prior authorization is required for conditions other than cancer.	HHO-DE-MP-1105 Bone Mineral Density Studies	EviCore. Prior authorization is managed b EviCore. Prior authorization is managed b
77084 77299 77371 77372 77373 77385 77386 77386 77387 77389	Computed tomography, bone mineral density study, 1 or more sites, axial skeleton (eg, hips, pelvis, spine) Magnetic resonance (eg, proton) imaging, bone marrow blood supply Unlisted procedure, therapeutic radiology clinical treatment planning Radiation treatment delivery, stereotactic radiosurgery (SRS), complete course of treatment of cranial lesion(s) consisting of 1 session; multi-source Cobalt 60 based Radiation treatment delivery, stereotactic radiosurgery (SRS), complete course of treatment of cranial lesion(s) consisting of 1 session; linear accelerator based Stereotactic body radiation therapy, treatment delivery, per fraction to 1 or more lesions, including image guidance, entire course not to exceed 5 fractions Intensity modulated radiation treatment delivery (INRT), includes guidance and tracking, when performed; simple Intensity modulated radiation treatment delivery (INRT), includes guidance and tracking, when performed; complex Guidance for localization of target volume for delivery of radiation treatment, includes intrafraction tracking, when performed Unlisted procedure, medical radiation physics, dosimetry and treatment devices and special services	Prior authorization is required and managed by EviCore. Reference policies for additional information. Prior authorization is managed by EviCore. Prior authorization is required. Prior authorization is required for conditions other than cancer. Prior authorization is required. Prior authorization is required. Prior authorization is required. Prior authorization is required for conditions other than cancer. Prior authorization is required for conditions other than cancer.	HHO-DE-MP-1105 Bone Mineral Density Studies	EviCore. Prior authorization is managed l EviCore. Prior authorization is managed l
77084 77299 77371 77372 77373 77385 77386 77387	Computed tomography, bone mineral density study, 1 or more sites, axial skeleton (eg, hips, pelvis, spine) Magnetic resonance (eg, proton) imaging, bone marrow blood supply Unlisted procedure, therapeutic radiology clinical treatment planning Radiation treatment delivery, stereotactic radiosurgery (SRS), complete course of treatment of cranial lesion(s) consisting of 1 session; multi-source Cobalt 60 based Radiation treatment delivery, stereotactic radiosurgery (SRS), complete course of treatment of cranial lesion(s) consisting of 1 session; linear accelerator based Stereotactic body radiation therapy, treatment delivery, per fraction to 1 or more lesions, including image guidance, entire course not to exceed 5 fractions Intensity modulated radiation treatment delivery (IMRT), includes guidance and tracking, when performed; simple Intensity modulated radiation of target volume for delivery of radiation treatment, includes intrafraction tracking, when performed Unlisted procedure, medical radiation physics, dosimetry and treatment, devices and	Prior authorization is required and managed by EviCore. Reference policies for additional information. Prior authorization is managed by EviCore. Prior authorization is required. Prior authorization is required for conditions other than cancer. Prior authorization is required. Prior authorization is required. Prior authorization is required. Prior authorization is required.	HHO-DE-MP-1105 Bone Mineral Density Studies	EviCore. Prior authorization is managed I EviCore. Prior authorization is managed I
77084 77299 77371 77372 77373 77385 77385 77386 77387 77387 77399 77401 77401	Computed tomography, bone mineral density study, 1 or more sites, axial skeleton (eg, hips, pelvis, spine) Magnetic resonance (eg, proton) imaging, bone marrow blood supply Unlisted procedure, therapeutic radiology clinical treatment planning Radiation treatment delivery, stereotactic radiosurgery (SRS), complete course of treatment of cranial lesion(s) consisting of 1 session; multi-source Cobalt 60 based Radiation treatment delivery, stereotactic radiosurgery (SRS), complete course of treatment of cranial lesion(s) consisting of 1 session; linear accelerator based Stereotactic body radiation therapy, treatment delivery, per fraction to 1 or more lesions, including image guidance, entire course not to exceed 5 fractions Intensity modulated radiation treatment delivery (INRT), includes guidance and tracking, when performed; simple Intensity modulated radiation treatment delivery (INRT), includes guidance and tracking, when performed; complex Guidance for localization of target volume for delivery of radiation treatment, includes intrafraction tracking, when performed Unlisted procedure, medical radiation physics, dosimetry and treatment devices and special services	Prior authorization is required and managed by EviCore. Reference policies for additional information. Prior authorization is managed by EviCore. Prior authorization is required. Prior authorization is required for conditions other than cancer. Prior authorization is required. Prior authorization is required. Prior authorization is required. Prior authorization is required for conditions other than cancer. Prior authorization is required for conditions other than cancer.	HHO-DE-MP-1105 Bone Mineral Density Studies	EviCore. Prior authorization is managed l EviCore. Prior authorization is managed l
77084 77299 77371 77372 77373 77385 77386 77386 77387 77387 77399 77401	Computed tomography, bone mineral density study, 1 or more sites, axial skeleton (eg, hips, pelvis, spine) Magnetic resonance (eg, proton) imaging, bone marrow blood supply Unlisted procedure, therapeutic radiology clinical treatment planning Radiation treatment delivery, stereotactic radiosurgery (SRS), complete course of treatment of cranial lesion(s) consisting of 1 session; multi-source Cobalt 60 based Radiation treatment delivery, stereotactic radiosurgery (SRS), complete course of treatment of cranial lesion(s) consisting of 1 session; multi-source Cobalt 60 based Radiation treatment delivery, stereotactic radiosurgery (SRS), complete course of treatment of cranial lesion(s) consisting of 1 session; linear accelerator based Stereotactic body radiation therapy, treatment delivery, per fraction to 1 or more lesions, including image guidance, entire course not to exceed 5 fractions Intensity modulated radiation treatment delivery (IMRT), includes guidance and tracking, when performed; simple Intensity modulated radiation treatment delivery (IMRT), includes guidance and tracking, when performed; simple Guidance for localization of traget volume for delivery of radiation treatment, includes intrafraction tracking, when performed Unlisted procedure, medical radiation physics, dosimetry and treatment devices and special services Radiation treatment delivery, superficial and/or ortho voltage, per day	Prior authorization is required and managed by EviCore. Reference policies for additional information. Prior authorization is managed by EviCore. Prior authorization is required. Prior authorization is required for conditions other than cancer. Prior authorization is required. Prior authorization is required. Prior authorization is required. Prior authorization is required. Prior authorization is required for conditions other than cancer. Prior authorization is required for conditions other than cancer.	HHO-DE-MP-1105 Bone Mineral Density Studies	EviCore. Prior authorization is managed b EviCore. Prior authorization is managed b

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

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78216	Liver & Spleen Imaging With Flow	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
78226	Hepatobiliary system imaging, including gallbladder when present;	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
78227	Hepatobiliary system imaging, including gallbladder when present; with pharmacologic intervention, including quantitative measurement(s) when performed	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
78230	Salivary Gland Imaging	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
78231	Serial Salivary Gland	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
78232	Salivary Gland Function Exam	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
78258	Esophogus Motility Study	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
78261	Gastric Mucosa Imaging	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
78262	Gastroesophageal Reflux Exam	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
78264	Gastric Emptying Study	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
78265	Gastric emptying imaging study (eg, solid, liquid, or both); with small bowel transit	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
78266	Gastric emptying imaging study (eg, solid, liquid, or both); with small bowel and colon transit, multiple days	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
78278	Gi Bleeder Scan	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
78290	Meckels Diverticulum Imaging	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
78291	Leveen Shunt Patency Exam	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
78299	Unlisted gastrointestinal procedure, diagnostic nuclear medicine	Prior authorization is required.		
78300	Bone and/or joint imaging; limited area	Prior authorization is required and managed by EviCore. Reference policies for additional information.	HHO-DE-MP-1136 Temporomandibular Joint Dysfunction	Prior authorization is managed b EviCore.
78305	Bone and/or joint imaging; multiple areas	Prior authorization is required and managed by EviCore. Reference policies for additional information.	HHO-DE-MP-1136 Temporomandibular Joint Dysfunction	Prior authorization is managed b EviCore.
78306	Bone Scan Whole Body	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
78315	Bone Scan 3 Phase Study	Prior authorization is managed by EviCore.		Prior authorization is managed b EviCore.
78399	Unlisted musculoskeletal procedure, diagnostic nuclear medicine	Prior authorization is required.		
78414	Non-Imaging Heart Function	Prior authorization is managed by EviCore.		Prior authorization is managed b EviCore.
78428	Cardiac Shunt I maging	Prior authorization is managed by EviCore.		Prior authorization is managed b EviCore.
78429	Myocardial imaging, positron emission tomography (PET), metabolic evaluation study (including ventricular wall motion[s] and/or ejection fraction[s], when performed), single study; with concurrently acquired computed tomography transmission scan	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
78430	Myocardial imaging, positron emission tomography (PET), perfusion study (including ventricular wall motion[s] and/or ejection fraction[s], when performed); single study, at rest or stress (exercise or phancologic), with concurrently acquired computed tomography transmission scan	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
78431	Myocardial imaging, positron emission tomography (PET), perfusion study (including ventricular wall motion[5] and/or ejection fraction[5], when performed); multiple studies at rest and stress (exercise or pharmacologic), with concurrently acquired computed tomography transmission scan	Prior authorization is managed by EviCore.		Prior authorization is managed b EviCore.
78432	Myocardial imaging, positron emission tomography (PET), combined perfusion with metabolic evaluation study (including ventricular wall motion[s] and/or ejection fraction[s], when performed), dual radiotracer (eg, myocardial viability);	Prior authorization is managed by EviCore.		Prior authorization is managed b EviCore.
78433	Myocardial imaging, positron emission tomography (PET), combined perfusion with metabolic evaluation study (including ventricular wall motion[s] and/or ejection fraction[s], when performed), dual radiotracer (eg, myocardial viability); with concurrently acquired computed tomography transmission scan	Prior authorization is managed by EviCore.		Prior authorization is managed b EviCore.
78434	Absolute quantitation of myocardial blood flow (AQMBF), positron emission tomography (PET), rest and pharmacologic stress (List separately in addition to code for primary procedure)	Prior authorization is managed by EviCore.		Prior authorization is managed b EviCore.
78445	Radionuclide Venogram Non-Cardiac	Prior authorization is managed by EviCore.		Prior authorization is managed b EviCore.
78451	78451 myocardial perfusion imaging, tomographic (spect) including attenuation correction, qualitative or quantitative wall motion, ejection fraction by first pass or gated technique, additional quantification, when performed); single study, at rest or stress (exercise or	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.

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	Myocardial perfusion imaging, tomographic (spect) (including attenuation correction, qualitative or quantitative wall motion, ejection fraction by first pass or gated technique,		Prior authorization is managed by
78452	additional quantification, when performed); multiple studies, at rest and/or stress (exercise	Prior authorization is managed by EviCore.	EviCore.
	or pharmacologic) and/or redistribution and/or rest reinjection		
	Myocardial perfusion imaging, planar (including qualitative or quantitative wall motion,		Prior authorization is managed b
78453	ejection fraction by first pass or gated technique, additional quantification, when	Prior authorization is managed by EviCore.	Frior authorization is managed b
	performed); single study, at rest or stress (exercise or pharmacologic)		Evicole.
	Myocardial perfusion imaging, planar (including qualitative or quantitative wall motion,		
78454	ejection fraction by first pass or gated technique, additional quantification, when	Prior authorization is managed by EviCore.	Prior authorization is managed b
70101	performed); multiple studies, at rest and/or stress (exercise or pharmacologic) and/or		EviCore.
	redistribution and/or rest reinjection		
78456	Acute Venous Thrombosis Imaging	Prior authorization is managed by EviCore.	Prior authorization is managed b
	••	σ,	EviCore.
78457	Venous Thrombosis Imaging Unilateral	Prior authorization is managed by EviCore.	Prior authorization is managed b
			EviCore.
78458	Venous Thrombosis Images, Bilateral	Prior authorization is managed by EviCore.	Prior authorization is managed b
			EviCore.
70450	Myocardial imaging, positron emission tomography (PET), metabolic evaluation study		Prior authorization is managed b
78459	(including ventricular wall motion[s] and/or ejection fraction[s], when performed), single	Prior authorization is managed by EviCore.	EviCore.
	study		Deine south a size til a second h
78466	Myocardial Infarction Scan	Prior authorization is managed by EviCore.	Prior authorization is managed b EviCore.
78468	Heart Infarct Image Ejection Fraction	Prior authorization is managed by EviCore.	Prior authorization is managed b EviCore.
78469	Heart Infarct Image 3D SPECT	Prior authorization is managed by EviCore.	Prior authorization is managed b
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78472	Cardiac Bloodpool Img, Single	Prior authorization is managed by EviCore.	Prior authorization is managed b
-			EviCore.
78473	Cardiac Bloodpool Img, Multi	Prior authorization is managed by EviCore.	Prior authorization is managed b
			EviCore.
78481	Heart First Pass Single	Prior authorization is managed by EviCore.	Prior authorization is managed b
			EviCore.
78483	Cardiac Blood Pool Imaging Multiple	Prior authorization is managed by EviCore.	Prior authorization is managed b
			EviCore.
	Myocardial imaging, positron emission tomography (PET), perfusion study(including		Prior authorization is managed b
78491	ventricular wall motion[s] and/or ejection fraction[s], when performed); single study, at	Prior authorization is managed by EviCore.	EviCore.
	rest or stress (exercise or pharmacologic)		
	Myocardial imaging, positron emission tomography (PET), perfusion study(including		Prior authorization is managed b
78492	ventricular wall motion[s] and/or ejection fraction[s], when performed); multiple studies at	Prior authorization is managed by EviCore.	EviCore.
	rest and/or stress (exercise or pharmacologic)		
78494	Cardiac Blood Pool Imaging , SPECT	Prior authorization is managed by EviCore.	Prior authorization is managed b
			EviCore.
	Cardiac blood pool imaging, gated equilibrium, single study, at rest, with right ventricular		Prior authorization is managed b
78496	ejection fraction by first pass technique (List separately in addition to code for primary	Prior authorization is managed by EviCore.	EviCore.
	procedure)		
78499	Unlisted Cardiovascular Procedure	Prior authorization is managed by EviCore.	Prior authorization is managed b
		с, ,	EviCore.
78579	Pulmonary ventilation imaging (eg, aerosol or gas)	Prior authorization is managed by EviCore.	Prior authorization is managed b
	,		EviCore.
78580	Pulmonary perfusion imaging (eg, particulate)	Prior authorization is managed by EviCore.	Prior authorization is managed b
,6566			EviCore.
78582	Pulmonary ventilation (eg, aerosol or gas) and perfusion imaging	Prior authorization is managed by EviCore.	Prior authorization is managed b
78582	Pulitonary venulation (eg, aerosor or gas) and perfusion imaging	Filor authorization is managed by Evicore.	EviCore.
78597	Quantitative differential pulmonary perfusion, including imaging when performed	Prior authorization is managed by EviCore.	Prior authorization is managed b
10551		The automation smallaged by Evicence.	EviCore.
78598	Quantitative differential pulmonary perfusion and ventilation (eg, aerosol or gas), including	Prior authorization is managed by EviCore.	Prior authorization is managed b
	imaging when performed	The automation smallaged by Evicence.	EviCore.
78599	Unlisted respiratory procedure, diagnostic nuclear medicine	Prior authorization is required.	
78600	Brain Imaging Limited Static	Prior authorization is managed by EviCore.	Prior authorization is managed b
70000	brain maging Limited State	The automation smallaged by Evicence.	EviCore.
78601	Brain Limited Imaging And Flow	Prior authorization is managed by EviCore.	Prior authorization is managed b
	Brain Einited magnig And How	Filor authorization is managed by Evicore.	EviCore.
		Prior authorization is managed by EviCore	Prior authorization is managed b
78605		Prior authorization is managed by EviCore.	EviCore.
78605	Brain Imaging Complete		
			Prior authorization is managed b
78605 78606	Brain Imaging Complete Brain Imaging Complete With Flow	Prior authorization is managed by EviCore.	Prior authorization is managed b EviCore.
78606	Brain I maging Complete With Flow		EviCore.
		Prior authorization is managed by EviCore. Prior authorization is managed by EviCore.	EviCore.
78606	Brain I maging Complete With Flow		Prior authorization is managed b

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

	Human Platelet Antigen 2 genotyping (HPA-2), GP1BA (glycoprotein Ib [platelet], alpha			
81106	polypeptide [GPIba]) (eg, neonatal alloimmune thrombocytopenia [NAIT], post-transfusion	Prior authorization is required.		
	purpura), gene analysis, common variant, HPA-2a/b (T145M)			
	Human Platelet Antigen 3 genotyping (HPA-3), ITGA2B (integrin, alpha 2b [platelet			
04407	glycoprotein IIb of IIb/IIIa complex], antigen CD41 [GPIIb]) (eg, neonatal alloimmune			
81107	thrombocytopenia [NAIT], post-transfusion purpura), gene analysis, common variant, HPA-	Prior authorization is required.		
	3a/b (1843S)			
	Human Platelet Antigen 4 genotyping (HPA-4), ITGB3 (integrin, beta 3 [platelet			
	glycoprotein IIIa], antigen CD61 [GPIIIa]) (eg, neonatal alloimmune thrombocytopenia			
81108	[NAIT], post-transfusion purpura), gene analysis, common variant, HPA-4a/b (R143Q)	Prior authorization is required.		
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	Human Platelet Antigen 5 genotyping (HPA-5), ITGA2 (integrin, alpha 2 [CD49B, alpha 2			
81109	subunit of VLA-2 receptor] [GPIa]) (eg, neonatal alloimmune thrombocytopenia [NAIT],	Prior authorization is required.		
	post-transfusion purpura), gene analysis, common variant (eg, HPA-5a/b [K505E])			
	Human Platelet Antigen 6 genotyping (HPA-6w), ITGB3 (integrin, beta 3 [platelet			
81110	glycoprotein IIIa, antigen CD61] [GPIIIa]) (eg, neonatal alloimmune thrombocytopenia	Prior authorization is required.		
01110	[NAIT], post-transfusion purpura), gene analysis, common variant, HPA-6a/b (R489Q)	ino autorizatorisrequirea		
	Human Platelet Antigen 9 genotyping (HPA-9w), ITGA2B (integrin, alpha 2b [platelet			
81111	glycoprotein IIb of IIb/IIIa complex, antigen CD41] [GPIIb]) (eg, neonatal alloimmune	Prior authorization is required.		
	thrombocytopenia [NAIT], post-transfusion purpura), gene analysis, common variant, HPA-			
	9a/b (V837M)			
	Human Platelet Antigen 15 genotyping (HPA-15), CD109 (CD109 molecule) (eg, neonatal			
81112	alloimmune thrombocytopenia [NAIT], post-transfusion purpura), gene analysis, common	Prior authorization is required.		
	variant, HPA-15a/b (S682Y)			
	IDH1 (isocitrate dehydrogenase 1 [NADP+], soluble) (eg, glioma), common variants (eg,			
81120	R132H.R132C)	Prior authorization is required.		
	IDH2 (isocitrate dehydrogenase 2 [NADP+], mitochondrial) (eg, glioma), common variants			
81121	(eg, R140W, R172M)	Prior authorization is required.		
81161	DMD (dystrophin) (eg, Duchenne/Becker muscular dystrophy) deletion analysis and	Prior authorization is required.		
	duplication analysis, if performed	'		
	BRCA1 (BRCA1, DNA repair associated), BRCA2 (BRCA2, DNA repair associated) (eg,			
81162	hereditary breast and ovarian cancer) gene analysis; full sequence analysis and full	Prior authorization is required. Reference policies for additional information.		
	duplication/deletion analysis (ie, detection of large gene rearrangements)			
	BRCA1 (BRCA1, DNA repair associated), BRCA2 (BRCA2, DNA repair associated) (eg,		HHO-DE-MP-1250 BRCA1 & BRCA2 Genetic Mutation Testing	
81163	hereditary breast and ovarian cancer) gene analysis; full sequence analysis	Prior authorization is required. Reference policies for additional information.	and Related Genetic Counseling	
	BRCA1 (BRCA1, DNA repair associated), BRCA2 (BRCA2, DNA repair associated) (eg,			
81164	hereditary breast and ovarian cancer) gene analysis; full duplication/deletion analysis (ie,	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1250 BRCA1 & BRCA2 Genetic Mutation Testing	
81104		Phor autionization is required. Relefence policies for auditional mormation.	and Related Genetic Counseling	
	detection of large gene rearrangements)			
81165	BRCA1 (BRCA1, DNA repair associated) (eg, hereditary breast and ovarian cancer) gene	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1250 BRCA1 & BRCA2 Genetic Mutation Testing	
	analysis; full sequence analysis	· · · · · · · · · · · · · · · · · · ·	and Related Genetic Counseling	
81166	BRCA1 (BRCA1, DNA repair associated) (eg, hereditary breast and ovarian cancer) gene	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1250 BRCA1 & BRCA2 Genetic Mutation Testing	
81100	analysis; full duplication/deletion analysis (ie, detection of large gene rearrangements)	Filor autionzation is required, Relefence poncies for auditional information.	and Related Genetic Counseling	
	BRCA2 (BRCA2, DNA repair associated) (eg, hereditary breast and ovarian cancer) gene		HHO-DE-MP-1250 BRCA1 & BRCA2 Genetic Mutation Testing	
81167	analysis; full duplication/deletion analysis (ie, detection of large gene rearrangements)	Prior authorization is required. Reference policies for additional information.	and Related Genetic Counseling	
	CCND1/IGH (t(11;14)) (eg, mantle cell lymphoma) translocation analysis, major break point,			
81168		Prior authorization is required.		
	qualitative and quantitative, if performed		HUO DE MD 103E DCD DI 1 Tertine in Channis March	
81170	ABL1 (ABL proto-oncogene 1, non-receptor tyrosine kinase) (eg, acquired imatinib tyrosine	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1035 BCR-BL1 Testing in Chronic Myeologenous	
	kinase inhibitor resistance), gene analysis, variants in the kinase domain	·····	Leukemia	
81171	AFF2 (ALF transcription elongation factor 2 [FMR2]) (eg, fragile X intellectual disability 2	Prior authorization is required.		
511/1	[FRAXE]) gene analysis; evaluation to detect abnormal (eg, expanded) alleles	The action action brequired.		
	AFF2 (ALF transcription elongation factor 2 [FMR2]) (eg, fragile X intellectual disability 2			
81172	[FRAXE]) gene analysis; characterization of alleles (eg, expanded size and methylation	Prior authorization is required.		
	status)	·		
	AR (androgen receptor) (eg, spinal and bulbar muscular atrophy, Kennedy disease, X		1	
81173	chromosome inactivation) gene analysis; full gene sequence	Prior authorization is required.		
<u>├</u> ────	AR (androgen receptor) (eg, spinal and bulbar muscular atrophy, Kennedy disease, X		1	
81174		Prior authorization is required.		
	chromosome inactivation) gene analysis; known familial variant	•		
1	ASXL1 (additional sex combs like 1, transcriptional regulator) (eg, myelodysplastic			
81175	syndrome, myeloproliferative neoplasms, chronic myelomonocytic leukemia), gene	Prior authorization is required.		
	analysis; full gene sequence			
	ASXL1 (additional sex combs like 1, transcriptional regulator) (eg, myelodysplastic			
81176	syndrome, myeloproliferative neoplasms, chronic myelomonocytic leukemia), gene	Prior authorization is required.		
	analysis; targeted sequence analysis (eg, exon 12)			
	ATN1 (atrophin 1) (eg, dentatorubral-pallidoluysian atrophy) gene analysis, evaluation to		1	
81177	detect abnormal (eg, expanded) alleles	Prior authorization is required.		
	ATXN1 (ataxin 1) (eg, spinocerebellar ataxia) gene analysis, evaluation to detect abnormal			
81178		Prior authorization is required.		
	(eg, expanded) alleles			
81179	ATXN2 (ataxin 2) (eg, spinocerebellar ataxia) gene analysis, evaluation to detect abnormal	Prior authorization is required.		
L	(eg, expanded) alleles			
81180	ATXN3 (ataxin 3) (eg, spinocerebellar ataxia, Machado-Joseph disease) gene analysis,	Prior authorization is required.		
	evaluation to detect abnormal (eg, expanded) alleles	·····		

81181	ATXN7 (ataxin 7) (eg, spinocerebellar ataxia) gene analysis, evaluation to detect abnormal (eg, expanded) alleles	Prior authorization is required.		
81182	ATXN8OS (ATXN8 opposite strand [non-protein coding]) (eg, spinocerebellar ataxia) gene analysis, evaluation to detect abnormal (eg, expanded) alleles	Prior authorization is required.		
81183	ATXN10 (ataxin 10) (eg, spinocerebellar ataxia) gene analysis, evaluation to detect abnormal (eg, expanded) alleles	Prior authorization is required.		
81184	CACNA1A (calcium voltage-gated channel subunit alpha1 A) (eg, spinocerebellar ataxia) gene analysis; evaluation to detect abnormal (eg, expanded) alleles	Prior authorization is required.		
81185	CACNA1A (calcium voltage-gated channel subunit alpha1 A) (eg, spinocerebellar ataxia) gene analysis; full gene sequence	Prior authorization is required.		
81186	CACNA1A (calcium voltage-gated channel subunit alpha1 A) (eg, spinocerebellar ataxia) gene analysis; known familial variant	Prior authorization is required.		
81187	CNBP (CCHC-type zinc finger nucleic acid binding protein) (eg. myotonic dystrophy type 2) gene analysis, evaluation to detect abnormal (eg., expanded) alleles	Prior authorization is required.		
81188	CSTB (cystatin B) (eg, Unverricht-Lundborg disease) gene analysis; evaluation to detect abnormal (eg, expanded) alleles	Prior authorization is required.		
81189	CSTB (cystatin B) (eg, Unverricht-Lundborg disease) gene analysis; full gene sequence	Prior authorization is required.		
	CSTB (cystatin B) (eg, Unverricht-Lundborg disease) gene analysis; known familial			
81190	variant(s)	Prior authorization is required.		
81191	NTRK1 (neurotrophic receptor tyrosine kinase 1) (eg, solid tumors) translocation analysis	Prior authorization is required.		
81192	NTRK2 (neurotrophic receptor tyrosine kinase 2) (eg, solid tumors) translocation analysis	Prior authorization is required.		
81193	NTRK3 (neurotrophic receptor tyrosine kinase 3) (eg, solid tumors) translocation analysis	Prior authorization is required.		
81194	NTRK (neurotrophic receptor tyrosine kinase 1, 2 and 3) (eg, solid tumors) translocation analysis	Prior authorization is required.		
81200	ASPA (aspartoacylase) (eg, Canavan disease) gene analysis, common variants (eg, E285A, Y231X)	Prior authorization is required.		
81201	APC (adenomatous polyposis coli) (eg, familial adenomatosis polyposis [FAP], attenuated FAP) gene analysis; full gene sequence	Prior authorization is required.		
81202	APC (adenomatous polyposis coli) (eg, familial adenomatosis polyposis [FAP], attenuated FAP) gene analysis; known familial variants	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1207 Genetic Testing for Colorectal Cancer Susceptibility	
81203	APC (adenomatous polyposis coli) (eg, familial adenomatosis polyposis [FAP], attenuated FAP) gene analysis; duplication/deletion variants	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1207 Genetic Testing for Colorectal Cancer Susceptibility	
81204	AR (androgen receptor) (eg, spinal and bulbar muscular atrophy, Kennedy disease, X chromosome inactivation) gene analysis; characterization of alleles (eg, expanded size or methylation status)	Prior authorization is required.		
81205	BCKDHB (branched-chain keto acid dehydrogenase E1, beta polypeptide) (eg, maple syrup urine disease) gene analysis, common variants (eg, R183P, G2785, E422X)	Prior authorization is required.		
81206	BCR/ABL1 (t(9;22)) (eg, chronic myelogenous leukemia) translocation analysis; major breakpoint, qualitative or quantitative	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1035 BCR-BL1 Testing in Chronic Myeologenous Leukemia	
81207	BCR/ABL1 (t(9;22)) (eg, chronic myelogenous leukemia) translocation analysis; minor breakpoint, qualitative or quantitative	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1035 BCR-BL1 Testing in Chronic Myeologenous Leukemia	
81208	BCR/ABL1 (t(9;22)) (eg, chronic myelogenous leukemia) translocation analysis; other breakpoint, qualitative or quantitative	Prior authorization is required.		
81209	BLM (Bloom syndrome, RecQ helicase-like) (eg, Bloom syndrome) gene analysis, 2281del6ins7 variant	Prior authorization is required.		
81210	BRAF (B-Raf proto-oncogene, serine/threonine kinase) (eg, colon cancer, melanoma), gene analysis, V600 variant(s)	Prior authorization is required.		
81212	BRCA1 (BRCA1, DNA repair associated), BRCA2 (BRCA2, DNA repair associated) (eg, hereditary breast and ovarian cancer) gene analysis; 185delAG, 5385insC, 6174delT variants	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1250 BRCA1 & BRCA2 Genetic Mutation Testing and Related Genetic Counseling	
81215	BRCA1 (BRCA1, DNA repair associated) (eg, hereditary breast and ovarian cancer) gene analysis; known familial variant	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1250 BRCA1 & BRCA2 Genetic Mutation Testing and Related Genetic Counseling	
81216	BRCA2 (BRCA2, DNA repair associated) (eg, hereditary breast and ovarian cancer) gene analysis; full sequence analysis	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1250 BRCA1 & BRCA2 Genetic Mutation Testing and Related Genetic Counseling	
81217	BRCA2 (BRCA2, DNA repair associated) (eg, hereditary breast and ovarian cancer) gene analysis; known familial variant	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1250 BRCA1 & BRCA2 Genetic Mutation Testing and Related Genetic Counseling	
81218	CEBPA (CCAAT/enhancer binding protein [C/EBP], alpha) (eg, acute myeloid leukemia), gene analysis, full gene sequence	Prior authorization is required.		
81219	CALR (calreticulin) (eg, myeloproliferative disorders), gene analysis, common variants in exon 9	Prior authorization is required.		
81220	CFTR (cystic fibrosis transmembrane conductance regulator) (eg, cystic fibrosis) gene analysis; common variants (eg, ACMG/ACOG guidelines)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1002 Pharmacogenomic Testing	
81221	CFTR (cystic fibrosis transmembrane conductance regulator) (eg, cystic fibrosis) gene analysis; known familial variants	Prior authorization is required.		
81222	CFTR (cystic fibrosis transmembrane conductance regulator) (eg, cystic fibrosis) gene analysis; duplication/deletion variants	Prior authorization is required.		
81223	CFTR (cystic fibrosis transmembrane conductance regulator) (eg, cystic fibrosis) gene analysis; full gene sequence	Prior authorization is required.		
81224	CFTR (cystic fibrosis transmembrane conductance regulator) (eg, cystic fibrosis) gene analysis; intron 8 poly-T analysis (eg, male infertility)	Prior authorization is required.		

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81225	CYP2C19 (cytochrome P450, family 2, subfamily C, polypeptide 19) (eg, drug metabolism), gene analysis, common variants (eg, *2, *3, *4, *8, *17)	Prior authorization is required.		
81226	CYP2D6 (cytochrome P450, family 2, subfamily D, polypeptide 6) (eg, drug metabolism), gene analysis, common variants (eg, *2, *3, *4, *5, *6, *9, *10, *17, *19, *29, *35, *41, *1XN, *2XN, *4XN)	Prior authorization is required.		
81227	CYP2C9 (cytochrome P450, family 2, subfamily C, polypeptide 9) (eg, drug metabolism), gene analysis, common variants (eg, *2, *3, *5, *6)	Prior authorization is required.		
81228	Cytogenomic (genome-wide) analysis for constitutional chromosomal abnormalities; interrogation of genomic regions for copy number variants, comparative genomic hybridization (ICGH) microarray analysis	Prior authorization is required.		
81229	Cytogenomic (genome-wide) analysis for constitutional chromosomal abnormalities; interrogation of genomic regions for copy number and single nucleotide polymorphism (SNP) variants, comparative genomic hybridization (CGH) microarray analysis	Prior authorization is required.		
81230	CYP3A4 (cytochrome P450 family 3 subfamily A member 4) (eg, drug metabolism), gene analysis, common variant(s) (eg, 2, 22)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1002 Pharmacogenomic Testing	
81231	CYP3A5 (cytochrome P450 family 3 subfamily A member 5) (eg, drug metabolism), gene analysis, common variants (eg, 2, 3, 4, 5, 6, 7)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1002 Pharmacogenomic Testing	
81232	DPYD (dihydropyrimidine dehydrogenase) (eg, 5-fluorouracil/5-FU and capecitabine drug metabolism), gene analysis, common variant(s) (eg, 2A, 4, 5, 6)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1002 Pharmacogenomic Testing	
81233	BTK (Bruton's tyrosine kinase) (eg, chronic lymphocytic leukemia) gene analysis, common variants (eg, C4815, C481F, C481F)	Prior authorization is required.		
81234	DMPK (DM1 protein kinase) (eg, myotonic dystrophy type 1) gene analysis; evaluation to detect abnormal (expanded) alleles	Prior authorization is required.		
81235	EGFR (epidermal growth factor receptor) (eg, non-small cell lung cancer) gene analysis, common variants (eg, exon 19 LREA deletion, L858R, T790M, G719A, G719S, L861Q)	Prior authorization is required.		
81236	EZH2 (enhancer of zeste 2 polycomb repressive complex 2 subunit) (eg, myelodysplastic syndrome, myeloproliferative neoplasms) gene analysis, full gene sequence	Prior authorization is required.		
81237	EZH2 (enhancer of zeste 2 polycomb repressive complex 2 subunit) (eg, diffuse large B-cell lymphoma) gene analysis, common variant(s) (eg, codon 646)	Prior authorization is required.		
81238	F9 (coagulation factor IX) (eg, hemophilia B), full gene sequence	Prior authorization is required.		
81239	DMPK (DM1 protein kinase) (eg, myotonic dystrophy type 1) gene analysis; characterization of alleles (eg, expanded size)	Prior authorization is required.		
81240	F2 (prothrombin, coagulation factor II) (eg, hereditary hypercoagulability) gene analysis, 20210GA variant	Prior authorization is required.		
81241	F5 (coagulation factor V) (eg, hereditary hypercoagulability) gene analysis, Leiden variant	Prior authorization is required.		
81242	FANCC (Fanconi anemia, complementation group C) (eg, Fanconi anemia, type C) gene analysis, common variant (eg, IVS4+4A>T)	Prior authorization is required.		
81243	FMR1 (fragile X messenger ribonucleoprotein 1) (eg, fragile X syndrome, X-linked intellectual disability [XLID]) gene analysis; evaluation to detect abnormal (eg, expanded)	Prior authorization is required.		
81244	alleles FMR1 (fragile X messenger ribonucleoprotein 1) (eg, fragile X syndrome, X-linked intellectual disability (XLID]) gene analysis; characterization of alleles (eg, expanded size and promoter methylation status)	Prior authorization is required.		
81245	FLT3 (fms-related tyrosine kinase 3) (eg, acute myeloid leukemia), gene analysis; internal tandem duplication (ITD) variants (ie, exons 14, 15)	Prior authorization is required.		
81246	FLT3 (fms-related tyrosine kinase 3) (eg, acute myeloid leukemia), gene analysis; tyrosine kinase domain (TKD) variants (eg, D835, I836)	Prior authorization is required.		
81247	G6PD (glucose-6-phosphate dehydrogenase) (eg, hemolytic anemia, jaundice), gene analysis; common variant(s) (eg, A, A-)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1002 Pharmacogenomic Testing	
81248	G6PD (glucose-6-phosphate dehydrogenase) (eg, hemolytic anemia, jaundice), gene analysis; known familial variant(s)	Prior authorization is required.		
81249	G6PD (glucose-6-phosphate dehydrogenase) (eg, hemolytic anemia, jaundice), gene analysis; full gene sequence	Prior authorization is required.		
81250	G6PC (glucose-6-phosphatase, catalytic subunit) (eg, Glycogen storage disease, type 1a, von Gierke disease) gene analysis, common variants (eg, R83C, Q347X)	Prior authorization is required.		
81251	GBA (glucosidase, beta, acid) (eg, Gaucher disease) gene analysis, common variants (eg, N370S, 84GG, L444P, IVS2+1G>A)	Prior authorization is required.		
81252	GJB2 (gap junction protein, beta 2, 26kDa, connexin 26) (eg, nonsyndromic hearing loss) gene analysis; full gene sequence	Prior authorization is required.		
81253	GJB2 (gap junction protein, beta 2, 26kDa, connexin 26) (eg, nonsyndromic hearing loss) gene analysis; known familial variants	Prior authorization is required.		
81254	GJB6 (gap junction protein, beta 6, 30kDa, connexin 30) (eg, nonsyndromic hearing loss) gene analysis, common variants (eg, 309kb [del(GJB6-D1351830)] and 232kb [del(GJB6- D1351854]])	Prior authorization is required.		
81255	HEXA (hexosaminidase A [alpha polypeptide]) (eg, Tay-Sachs disease) gene analysis, common variants (eg, 1278insTATC, 1421+1G>C, G269S)	Prior authorization is required.		
81256	HFE (hemochromatosis) (eg, hereditary hemochromatosis) gene analysis, common variants (eg, C282Y, H63D)	Prior authorization is required.		
81257	HBA1/HBA2 (alpha globin 1 and alpha globin 2) (eg, alpha thalassemia, Hb Bart hydrops fetalis syndrome, HbH disease), gene analysis; common deletions or variant (eg, Southeast Asian, Thai, Filipino, Mediterranean, alpha3.7, alpha4.2, alpha20.5, Constant Spring)	Prior authorization is required.		
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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 is required.		
81259	HBA1/HBA2 (alpha globin 1 and alpha globin 2) (eg, alpha thalassemia, Hb Bart hydrops fetalis syndrome, HbH disease), gene analysis; full gene sequence	Prior authorization is required.		
	IKBKAP (inhibitor of kappa light polypeptide gene enhancer in B-cells, kinase complex-			
81260	associated protein) (eg, familial dysautonomia) gene analysis, common variants (eg, 2507+6T>C, R696P)	Prior authorization is required.		
81261	IGH@ (Immunoglobulin heavy chain locus) (eg, leukemias and lymphomas, B-cell), gene rearrangement analysis to detect abnormal clonal population(s); amplified methodology	Prior authorization is required.		
	(eg, polymerase chain reaction) IGH@ (Immunoglobulin heavy chain locus) (eg, leukemias and lymphomas, B-cell), gene			
81262	rearrangement analysis to detect abnormal clonal population(s); direct probe methodology (eg, Southern blot)	Prior authorization is required.		
81263	IGH@ (Immunoglobulin heavy chain locus) (eg, leukemia and lymphoma, B-cell), variable region somatic mutation analysis	Prior authorization is required.		
81264	IGK@ (Immunoglobulin kappa light chain locus) (eg, leukemia and lymphoma, B-cell), gene rearrangement analysis, evaluation to detect abnormal clonal population(s)	Prior authorization is required.		
81265	Comparative analysis using Short Tandem Repeat (STR) markers; patient and comparative specimen (eg, pre-transplant recipient and donor germline testing, post-transplant non- hematopoietic recipient germline [eg, buccal swab or other germline tissue sample] and donor testing, twin zygosity testing, or maternal cell contamination of fetal cells)	Prior authorization is required.		
81266	Comparative analysis using Short Tandem Repeat (STR) markers; each additional specimen (eg. additional cord blood donor, additional fetal samples from different cultures, or additional zygosity in multiple birth pregnancies) (List separately in addition to code for primary procedure)	Prior authorization is required.		
81267	Chimerism (engraftment) analysis, post transplantation specimen (eg, hematopoietic stem cell), includes comparison to previously performed baseline analyses; without cell selection	Prior authorization is required.		
81268	Chimerism (engraftment) analysis, post transplantation specimen (eg, hematopoietic stem cell), includes comparison to previously performed baseline analyses; with cell selection (eg, CD3, CD33), each cell type	Prior authorization is required.		
81269	HBA1/HBA2 (alpha globin 1 and alpha globin 2) (eg, alpha thalassemia, Hb Bart hydrops fetalis syndrome, HbH disease), gene analysis; duplication/deletion variants	Prior authorization is required.		
81270	JAK2 (Janus kinase 2) (eg, myeloproliferative disorder) gene analysis, p. Val617Phe (V617F) variant	Prior authorization is required.		
81271	HTT (huntingtin) (eg, Huntington disease) gene analysis; evaluation to detect abnormal (eg, expanded) alleles	Prior authorization is required.		
81272	KIT (v-kit Hardy-Zuckerman 4 feline sarcoma viral oncogene homolog) (eg. gastrointestinal stromal tumor [GIST], acute myeloid leukernia, melanoma), gene analysis, targeted sequence analysis (eg. exons 8, 11, 13, 17, 18)	Prior authorization is required.		
81273	KIT (v-kit Hardy-Zuckerman 4 feline sarcoma viral oncogene homolog) (eg, mastocytosis), gene analysis, D816 variant(s)	Prior authorization is required.		
81274	HTT (huntingtin) (eg, Huntington disease) gene analysis; characterization of alleles (eg, expanded size)	Prior authorization is required.		
81275	KRAS (Kirsten rat sarcoma viral oncogene homolog) (eg, carcinoma) gene analysis; variants in exon 2 (eg, codons 12 and 13)	Prior authorization is required.		
81276	KRAS (Kirsten rat sarcoma viral oncogene homolog) (eg, carcinoma) gene analysis; additional variant(s) (eg, codon 61, codon 146)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1028 Molecular Tumor Markers for Non-Small Lung Cancer	
81277	Cytogenomic neoplasia (genome-wide) microarray analysis, interrogation of genomic regions for copy number and uss-of-heterozygosity variants for chromosomal abnormalities	Prior authorization is required.		
81278	IGH@/BCL2 (t[14;18]) (eg, follicular lymphoma) translocation analysis, major breakpoint region (MBR) and minor cluster region (mcr) breakpoints, qualitative or quantitative	Prior authorization is required.		
81279	JAK2 (Janus kinase 2) (eg, myeloproliferative disorder) targeted sequence analysis (eg, exons 12 and 13)	Prior authorization is required.		
81283	IFNL3 (interferon, lambda 3) (eg, drug response), gene analysis, rs12979860 variant	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1002 Pharmacogenomic Testing	
81284	FXN (frataxin) (eg, Friedreich ataxia) gene analysis; evaluation to detect abnormal	Prior authorization is required.		
81285	(expanded) alleles FXN (frataxin) (eg, Friedreich ataxia) gene analysis; characterization of alleles (eg, expanded size)	Prior authorization is required.		
81286	FXN (frataxin) (eg, Friedreich ataxia) gene analysis; full gene sequence	Prior authorization is required.		
81287	MGMT (0-6-methylguanine-DNA methyltransferase) (eg, glioblastoma multiforme) promoter methylation analysis	Prior authorization is required.		
81288	MLH1 (mutL homolog 1, colon cancer, nonpolyposis type 2) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; promoter methylation analysis	Prior authorization is required.		
81289	FXN (frataxin) (eg, Friedreich ataxia) gene analysis; known familial variant(s)	Prior authorization is required.		
81290	MCOLN1 (mucolipin 1) (eg, Mucolipidosis, type IV) gene analysis, common variants (eg, IVS3-2A>G, del6.4kb)	Prior authorization is required.		
81291	MTHFR (5,10-methylenetetrahydrofolate reductase) (eg, hereditary hypercoagulability) gene analysis, common variants (eg, 677T, 1298C)	Prior authorization is required.		

81292 MLH1 (mutt. homolog 1, colon cancer, nonpolyposis type 2) (eg., hereditar colorectal cancer, Lynch syndrome) gene analysis; full sequence 81293 81293 MLH1 (mutt. homolog 1, colon cancer, nonpolyposis type 2) (eg., hereditar colorectal cancer, Lynch syndrome) gene analysis; known familial 81294 81293 MLH1 (mutt. homolog 1, colon cancer, nonpolyposis type 2) (eg., hereditar colorectal cancer, Lynch syndrome) gene analysis; duplication/delet 81295 81294 MLH1 (mutt. homolog 2, colon cancer, nonpolyposis type 1) (eg., hereditar colorectal cancer, Lynch syndrome) gene analysis; full sequence. 81295 MSH2 (mut5 homolog 2, colon cancer, nonpolyposis type 1) (eg., hereditar colorectal cancer, Lynch syndrome) gene analysis; full sequence. 81296 MSH2 (mut5 homolog 2, colon cancer, nonpolyposis type 1) (eg., hereditar colorectal cancer, Lynch syndrome) gene analysis; honown familial 81297 81296 MSH2 (mut5 homolog 2, colon cancer, nonpolyposis type 1) (eg., hereditar colorectal cancer, Lynch syndrome) gene analysis; duplication/delet 81298 81299 MSH6 (mut5 homolog 6 [E. coli]) (eg., hereditary non-polyposis colorect syndrome) gene analysis; full sequence analysis 81300 MSH6 (mut5 homolog 6 [E. coli]) (eg., hereditary non-polyposis colorect syndrome) gene analysis; duplication/deletion variants 81301 MSH6 (mut5 homolog 6 [E. coli]) (eg., hereditary non-polyposis colorect syndrome) gene analysis; duplication/deletion variants 81301 MSH6 (mut5 homolog 6 [E. coli]	prior authorization is required. non-polyposis Prior authorization is required. ariants Prior authorization is required. non-polyposis Prior authorization is required. ariants Prior authorization is required. non-polyposis Prior authorization is required. ariants Prior authorization is required. cancer, Lynch Prior authorization is required.	HHO-DE-MP-1207 Genetic Testing for Colorectal Cancer
81293 colorectal cancer, Lynch syndrome) gene analysis; known familial 81294 MLH1 (mutL homolog 1, colon cancer, nonpolyposis type 2) (eg, heredital 81295 MSH2 (mutS homolog 2, colon cancer, nonpolyposis type 1) (eg, heredital 81296 MSH2 (mutS homolog 2, colon cancer, nonpolyposis type 1) (eg, heredital 81297 MSH2 (mutS homolog 2, colon cancer, nonpolyposis type 1) (eg, heredital 81296 MSH2 (mutS homolog 2, colon cancer, nonpolyposis type 1) (eg, heredital 81297 MSH2 (mutS homolog 2, colon cancer, nonpolyposis type 1) (eg, heredital 81298 MSH2 (mutS homolog 2, colon cancer, nonpolyposis type 1) (eg, heredital 81299 MSH6 (mutS homolog 2, Colon cancer, nonpolyposis type 1) (eg, heredital 81298 MSH6 (mutS homolog 6 [E. coli]) (eg, hereditary non-polyposis colorecta 81299 MSH6 (mutS homolog 6 [E. coli]) (eg, hereditary non-polyposis colorecta 81300 MSH6 (mutS homolog 6 [E. coli]) (eg, hereditary non-polyposis colorecta 81300 MSH6 (mutS homolog 6 [E. coli]) (eg, hereditary non-polyposis colorecta 81301 Syndrome) gene analysis; duplication/deletion variants 81301 Microsatellite instability analysis (eg, hereditary non-polyposis colorecta 81301 Microsatellite instability analysis (eg, hereditary non	Prior authorization is required. non-polyposis Prior authorization is required. non-polyposis Prior authorization is required. axiants Prior authorization is required. non-polyposis Prior authorization is required. non-polyposis Prior authorization is required. non-polyposis Prior authorization is required. ariants Prior authorization is required. cancer, Lynch Prior authorization is required.	
81294 colorectal cancer, Lynch syndrome) gene analysis; duplication/delet 81295 MSH2 (mutS homolog 2, colon cancer, nonpolyposis type 1) (eg, heredita colorectal cancer, Lynch syndrome) gene analysis; full sequence. 81296 MSH2 (mutS homolog 2, colon cancer, nonpolyposis type 1) (eg, heredita colorectal cancer, Lynch syndrome) gene analysis; full sequence. 81296 MSH2 (mutS homolog 2, colon cancer, nonpolyposis type 1) (eg, heredita colorectal cancer, Lynch syndrome) gene analysis; knuplication/delet 81297 MSH2 (mutS homolog 2, colon cancer, nonpolyposis type 1) (eg, heredita colorectal cancer, Lynch syndrome) gene analysis; full sequence analysis 81298 MSH6 (mutS homolog 6 [E, coli]) (eg, hereditary non-polyposis colorecta syndrome) gene analysis; full sequence analysis 81299 MSH6 (mutS homolog 6 [E, coli]) (eg, hereditary non-polyposis colorecta syndrome) gene analysis; full sequence analysis 81300 MSH6 (mutS homolog 6 [E, coli]) (eg, hereditary non-polyposis colorecta syndrome) gene analysis; duplication/deletion variants 81301 Microsatellite instability analysis (eg, hereditary non-polyposis colorecta syndrome) of markers for mismatch repair deficiency (eg, RAT25, RAT comparison of neoplastic and normal tissue, if performed 81302 MECP2 (methyl CpG binding protein 2) (eg, Rett syndrome) gene analysis 81303 MECP2 (methyl CpG binding protein 2) (eg, Rett syndrome) gene analysis	Prior authorization is required. non-polyposis alysis Prior authorization is required. non-polyposis ariants Prior authorization is required. non-polyposis ariants Prior authorization is required. non-polyposis nvariants Prior authorization is required. cancer, Lynch Prior authorization is required.	
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81290 colorectal cancer, Lynch syndrome) gene analysis; known familial 81297 MSH2 (mut5 homolog 2, colon cancer, nonpolyposis type 1) (eg, heredita colorectal cancer, Lynch syndrome) gene analysis; duplication/delet 81298 MSH6 (mut5 homolog 6 [E. coli]) (eg, hereditary non-polyposis colorect syndrome) gene analysis; full sequence analysis 81299 MSH6 (mut5 homolog 6 [E. coli]) (eg, hereditary non-polyposis colorect syndrome) gene analysis; full sequence analysis 81300 MSH6 (mut5 homolog 6 [E. coli]) (eg, hereditary non-polyposis colorect syndrome) gene analysis; duplication/deletion variants 81300 MSH6 (mut5 homolog 6 [E. coli]) (eg, hereditary non-polyposis colorect syndrome) gene analysis; duplication/deletion variants 81301 Microsatellite instability analysis (eg, hereditary non-polyposis colorect syndrome) of markers for mismatch repair deficiency (eg, RAT25, BAT comparison of neoplastic and normal tissue, if performed 81302 81303 MECP2 (methyl CpG binding protein 2) (eg, Rett syndrome) gene analysis	ariants Prior authorization is required. non-polyposis nvariants Prior authorization is required. cancer, Lynch Prior authorization is required.	
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analysis MECP2 (methyl CpG binding protein 2) (eg, Rett syndrome) gene analysis		Susceptibility
	full sequence Prior authorization is required.	
	Prior authorization is required.	
81304 MECP2 (methyl CpG binding protein 2) (eg, Rett syndrome) gene a duplication/deletion variants	alysis; Prior authorization is required.	
MYD88 (myeloid differentiation primary response 88) (eg. Walde 81305 macroglobulinemia, lymphoplasmacytic leukemia) gene analysis, p. Leu variant	55Pro (L265P) Prior authorization is required.	
81306 NUDT15 (nudix hydrolase 15) (eg, drug metabolism) gene analysis, comm *2, *3, *4, *5, *6)	variant(s) (eg, Prior authorization is required.	
81307 PALB2 (partner and localizer of BRCA2) (eg, breast and pancreatic cancer full gene sequence	ene analysis; Prior authorization is required.	
81308 PALB2 (partner and localizer of BRCA2) (eg, breast and pancreatic cancer known familial variant	ene analysis; Prior authorization is required.	
81309 PIK3CA (phosphatidylinositol-4, 5-biphosphate 3-kinase, catalytic subu colorectal and breast cancer) gene analysis, targeted sequence analysis (e	Prior authorization is required	
81310 NPM1 (nucleophosmin) (eg, acute myeloid leukemia) gene analysis, ex	12 variants Prior authorization is required.	
81311 NRAS (neuroblastoma RAS viral [v-ras] oncogene homolog) (eg, colorec gene analysis, variants in exon 2 (eg, codons 12 and 13) and exon 3 (e		
81312 PABPN1 (poly(A) binding protein nuclear 1) (eg, oculopharyngeal muscu gene analysis, evaluation to detect abnormal (eg, expanded) a	r dystrophy) Prior authorization is required	
81313 PCA3/KLK3 (prostate cancer antigen 3 [non-protein coding]/kallikrein-rela [prostate specific antigen]) ratio (eg, prostate cancer)		
81314 PDGFRA (platelet-derived growth factor receptor, alpha polypeptide) (eg, stromal tumor [GIST]), gene analysis, targeted sequence analysis (eg,		
PML/RARalpha, (t15;17), (promyelocytic leukemia/retinoic addrecep 81315 promyelocytic leukemia) translocation analysis; common breakpoints (intron 6), qualitative or quantitative		
PML/RARalpha, (t15;17)), (promyelocytic leukemia/retinoic acid rece; promyelocytic leukemia) translocation analysis; single breakpoint (eg, int exon 6), qualitative or quantitative		
81317 PMS2 (postmeiotic segregation increased 2 [S. cerevisiae]) (eg, hereditar colorectal cancer, Lynch syndrome) gene analysis; full sequence.		
81318 PMS2 (postmeiotic segregation increased 2 [S. cerevisiae]) (eg, hereditar colorectal cancer, Lynch syndrome) gene analysis; known familial	non-polyposis Prior authorization is required	
81319 PMS2 (postmeiotic segregation increased 2 [S. cerevisiae]) (eg. hereditar colorectal cancer, Lynch syndrome) gene analysis, duplication/delet	non-polyposis Prior authorization is required	
81320 PLCG2 (phospholipase C gamma 2) (eg, chronic lymphocytic leukemia); common variants (eg, R665W, S707F, L845F)	ne analysis, Prior authorization is required.	
81321 PTEN (phosphatase and tensin homolog) (eg, Cowden syndrome, PTEN h syndrome) gene analysis; full sequence analysis	Prior authorization is required.	
81322 PTEN (phosphatase and tensin homolog) (eg. Cowden syndrome, PTEN h syndrome) gene analysis; known familial variant	nartoma tumor Prior authorization is required.	
81323 PTEN (phosphatase and tensin homolog) (eg. Cowden syndrome, PTEN h syndrome) gene analysis; duplication/deletion variant	Prior authorization is required.	

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81324	PMP22 (peripheral myelin protein 22) (eg, Charcot-Marie-Tooth, hereditary neuropathy with liability to pressure palsies) gene analysis; duplication/deletion analysis	Prior authorization is required.		
81325	PMP22 (peripheral myelin protein 22) (eg, Charcot-Marie-Tooth, hereditary neuropathy with liability to pressure palsies) gene analysis; full sequence analysis	Prior authorization is required.		
81326	PMP22 (peripheral myelin protein 22) (eg, Charcot-Marie-Tooth, hereditary neuropathy	Prior authorization is required.		
81327	with liability to pressure palsies) gene analysis; known familial variant SEPT9 (Septin9) (eg, colorectal cancer) promoter methylation analysis	Prior authorization is required.		
	SLCO1B1 (solute carrier organic anion transporter family, member 1B1) (eg, adverse drug			
81328	reaction), gene analysis, common variant(s) (eg, 5) SMN1 (survival of motor neuron 1, telomeric) (eg, spinal muscular atrophy) gene analysis;	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1002 Pharmacogenomic Testing	
81329	dosage/deletion analysis (eg, carrier testing), includes SMN2 (survival of motor neuron 2, centromeric) analysis, if performed	Prior authorization is required.		
81330	SMPD1 (sphingomyelin phosphodiesterase 1, acid lysosomal) (eg, Niemann-Pick disease, Type A) gene analysis, common variants (eg, R496L, L302P, fsP330)	Prior authorization is required.		
81331	SNRPN/UBE3A (small nuclear ribonucleoprotein polypeptide N and ubiquitin protein ligase E3A) (eg, Prader-Willi syndrome and/or Angelman syndrome), methylation analysis	Prior authorization is required.		
81332	SERPINA1 (serpin peptidase inhibitor, clade A, alpha-1 antiproteinase, antitrypsin, member 1) (eg, alpha-1-antitrypsin deficiency), gene analysis, common variants (eg, *S and *Z)	Prior authorization is required.		
81333	TGFBI (transforming growth factor beta-induced) (eg, corneal dystrophy) gene analysis, common variants (eg, R124H, R124C, R124L, R555W, R555Q)	Prior authorization is required.		
81334	RUNX1 (runt related transcription factor 1) (eg, acute myeloid leukemia, familial platelet disorder with associated myeloid malignancy) gene analysis, targeted sequence analysis (eg, exons 3-8)	Prior authorization is required.		
81335	TPMT (thiopurine S-methyltransferase) (eg, drug metabolism), gene analysis, common variants (eg, 2, 3)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1002 Pharmacogenomic Testing	
81336	SMN1 (survival of motor neuron 1, telomeric) (eg, spinal muscular atrophy) gene analysis; full gene sequence	Prior authorization is required.		
81337	SMN1 (survival of motor neuron 1, telomeric) (eg, spinal muscular atrophy) gene analysis; known familial sequence variant(s)	Prior authorization is required.		
81338	MPL (MPL proto-oncogene, thrombopoietin receptor) (eg, myeloproliferative disorder) gene analysis; common variants (eg, W515A, W515K, W515L, W515R)	Prior authorization is required.		
81339	MPL (MPL proto-oncogene, thrombopoietin receptor) (eg, myeloproliferative disorder) gene analysis; sequence analysis, exon 10	Prior authorization is required.		
81340	TRB@ (T cell antigen receptor, beta) (eg, leukemia and lymphoma), gene rearrangement analysis to detect abnormal clonal population(s); using amplification methodology (eg, polymerase chain reaction)	Prior authorization is required.		
81341	TRB@ (T cell antigen receptor, beta) (eg, leukemia and lymphoma), gene rearrangement analysis to detect abnormal clonal population(s); using direct probe methodology (eg, Southern blot)	Prior authorization is required.		
81342	TRG@ (T cell antigen receptor, gamma) (eg, leukemia and lymphoma), gene rearrangement analysis, evaluation to detect abnormal clonal population(s)	Prior authorization is required.		
81343	PPP2R2B (protein phosphatase 2 regulatory subunit Bbeta) (eg, spinocerebellar ataxia) gene analysis, evaluation to detect abnormal (eg, expanded) alleles	Prior authorization is required.		
81344	TBP (TATA box binding protein) (eg, spinocerebellar ataxia) gene analysis, evaluation to detect abnormal (eg, expanded) alleles	Prior authorization is required.		
81345	TERT (telomerase reverse transcriptase) (eg, thyroid carcinoma, glioblastoma multiforme) gene analysis, targeted sequence analysis (eg, promoter region)	Prior authorization is required.		
81346	TYMS (thymidylate synthetase) (eg, 5-fluorouracii/5-FU drug metabolism), gene analysis, common variant(s) (eg, tandem repeat variant)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1002 Pharmacogenomic Testing	
81350	UGT1A1 (UDP glucuronosyltransferase 1 family, polypeptide A1) (eg, drug metabolism, hereditary unconjugated hyperbilirubinemia [Gilbert syndrome]) gene analysis, common variants (eg, *28, *36, *37)	Prior authorization is required.		
81351	TP53 (tumor protein 53) (eg, Li-Fraumeni syndrome) gene analysis; full gene sequence	Prior authorization is required.		
81353	TP53 (tumor protein 53) (eg, Li-Fraumeni syndrome) gene analysis; known familial variant	Prior authorization is required.		
81355	VKORC1 (vitamin K epoxide reductase complex, subunit 1) (eg, warfarin metabolism), gene analysis, common variant(s) (eg, -1639G>A, c.173+1000C>T)	Prior authorization is required.		
81361	HBB (hemoglobin, subunit beta) (eg, sickle cell anemia, beta thalassemia, hemoglobinopathy); common variant(s) (eg, HbS, HbC, HbE)	Prior authorization is required.		
81362	HBB (hemoglobin, subunit beta) (eg, sickle cell anemia, beta thalassemia, hemoglobinopathy); known familial variant(s)	Prior authorization is required.		
81363	HBB (hemoglobin, subunit beta) (eg, sickle cell anemia, beta thalassemia, hemoglobinopathy); duplication/deletion variant(s)	Prior authorization is required.		
81364	HBB (hemoglobin, subunit beta) (eg, sickle cell anemia, beta thalassemia, hemoglobinopathy); full gene sequence	Prior authorization is required.		
81370	HLA Class I and II typing, low resolution (eg, antigen equivalents); HLA-A, -B, -C, - DRB1/3/4/5 and -DQB1	Prior authorization is required.		
81371	HLA Class I and II typing, low resolution (eg, antigen equivalents); HLA-A, -B and -DRB1 (eg, verification typing)	Prior authorization is required.		
81372	HLA Class I typing, low resolution (eg, antigen equivalents); complete (ie, HLA-A, -B and -C)	Prior authorization is required.		
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81373	HLA Class I typing, low resolution (eg, antigen equivalents); one locus (eg, HLA-A, -B, or -C), each	Prior authorization is required.		
81374	HLA Class I typing, low resolution (eg, antigen equivalents); one antigen equivalent (eg, B*27), each	Prior authorization is required.		
81375	HLA Class II typing, low resolution (eg, antigen equivalents); HLA-DRB1/3/4/5 and -DQB1	Prior authorization is required.		
81376	HLA Class II typing, low resolution (eg, antigen equivalents); one locus (eg, HLA-DRB1, - DRB3/4/5, -DQB1, -DQA1, -DPB1, or -DPA1), each	Prior authorization is required.		
81377	HLA Class II typing, low resolution (eg, antigen equivalents); one antigen equivalent, each	Prior authorization is required.		
81378	HLA Class I and II typing, high resolution (ie, alleles or allele groups), HLA-A, -B, -C and - DRB1	Prior authorization is required.		
81379	HLA Class I typing, high resolution (ie, alleles or allele groups); complete (ie, HLA-A, -B and - C)	Prior authorization is required.		
81380	HLA Class I typing, high resolution (ie, alleles or allele groups); one locus (eg, HLA-A, -B, or - C), each	Prior authorization is required.		
81381	HLA Class I typing, high resolution (ie, alleles or allele groups); one allele or allele group (eg, B*57:01P), each	Prior authorization is required.		
81382	HLA Class II typing, high resolution (ie, alleles or allele groups); one locus (eg, HLA-DRB1, - DRB3/4/5, -DQB1, -DQA1, -DPB1, or -DPA1), each	Prior authorization is required.		
81383	HLA Class II typing, high resolution (ie, alleles or allele groups); one allele or allele group (eg, HLA-DQB1*06:02P), each	Prior authorization is required.		
81400	Molecular pathology procedure, Level 1 (eg, identification of single germline variant [eg, SNP] by techniques such as restriction enzyme digestion or melt curve analysis) ACADM (acyl-CoA dehydrogenase, C-4 to C-12 straight chain, MCAD) (eg, medium chain acyl dehydrogenase deficiency), K304E variant ACE (angiotensin converting enzyme) (eg, hereditary blood pressure regulation), insertion/deletion variant ACTR1 (angiotensin I) receptor, type 1) (eg, essential hypertension), 1166A>C variant BCKDHA (branched chain keto acid dehydrogenase E1, alpha polypeptide) (eg, maple syrup urine disease, type	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1210 Oncologic Genetic Testing Panels	
81401	Molecular pathology procedure, Level 2 (eg, 2-10 SNPs, 1 methylated variant, or 1 somatic variant [typically using nonsequencing target variant analysis], or detection of a dynamic mutation disorder/triplet repeat) ABCCB (ATP-binding cassette, sub-family C [CFTR/MAP], member 8) (eg, familial hyperinsulinism), common variants (eg, c. 3898-9G>A [c. 3992- 9G>A], F1384ed) ABL1 (ABL proto-oncogene 1, non-receptor tyrosine kinase) (eg, acquired imatinib resistance), T3151 variant ACADM (acyl-CoA dehydrogenase, C-4 to C-12 straight chain, MCAD) (eg, medium chain acyl dehydrogenase deficiency), commons	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1207 Genetic Testing for Colorectal Cancer Susceptibility and HHO-DE-MP-1210 Oncologic Genetic Testing Panels	
81402	Molecular pathology procedure, Level 3 (eg, >10 SNPs, 2-10 methylated variants, or 2-10 somatic variants [typically using non-sequencing target variant analysis], immunoglobulin and T-cell receptor gene rearrangements, duplication/deletion variants of 1 exon, loss of heterozygosity [LOH], uniparental disomy [UPD]) Chromosome 1p-/19q- (eg, glial tumors), deletion analysis Chromosome 18q- (eg, D18555, D18556, D18564 and D18569) (eg, colon cancer), allelic imbalance assessment (ie, loss of heterozygosity) COL1A1/PDGFB (t17;22)) (eg, dermatofibrosarcoma protuberans), translocation analys	Prior authorization is required.		
81403	Molecular pathology procedure, Level 4 (eg, analysis of single exon by DNA sequence analysis, analysis of >10 amplicons using multiplex PCR in 2 or more independent reactions, mutation scanning or duplication/deletion variants of 2-5 exons) ANG (angiogenin, ribonuclease, RNase A family, 5) (eg, amyotrophic lateral sclerosis), full gene sequence ARX (aristaless-related homeobox) (eg, X-linked lissencephaly with ambiguous genitalia, X- linked mental retardation), duplication/deletion analysis CEL (carbox/elster lipase [bile salt- stimulated lipase]) (eg, maturity-onset diabetes of the young [MODY	Prior authorization is required.		
81404	Molecular pathology procedure, Level 5 (eg, analysis of 2-5 exons by DNA sequence analysis, mutation scanning or duplication/deletion variants of 6-10 exons, or characterization of a dynamic mutation disorder/triplet repeat by Southern blot analysis) ACADS (acyl-CoA dehydrogenase, C-2 to C-3 short chain) (eg, short chain acyl-CoA dehydrogenase deficiency), targeted sequence analysis (eg, exons 5 and 6) AQP2 (aquaporin 2 [collecting duct]) (eg, nephrogenic diabetes insipidus), full gene sequence ARX (aristaless related homeobox) (eg, X-linked lissencephaly with ambiguous genitalia, X- linked men	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1210 Oncologic Genetic Testing Panels and HHO- DE-MP-1028 Molecular Tumor Markers for Non-Small Lung Cancer	
81405	Molecular pathology procedure, Level 6 (eg, analysis of 6-10 exons by DNA sequence analysis, mutation scanning or duplication/deletion variants of 11-25 exons, regionally targeted cytogenomic array analysis) ABCU (ATP-binding cassette, sub-family D [ALD], member 1) (eg, adrenoleukodystrophy), full gene sequence ACADS (acyl-CoA dehydrogenase, C-2 to C-3 short chain) (eg, short chain acyl-CoA dehydrogenase deficiency), full gene sequence ACTA2 (actin, alpha 2, smooth muscle, aorta) (eg, thoracic aortic aneurysms and aortic dissections), full gene sequence ACTC1 (actin, alpha, cardiac muscle 1)	Prior authorization is required.		

81406	Molecular pathology procedure, Level 7 (eg, analysis of 11-25 exons by DNA sequence analysis, mutation scanning or duplication/deletion variants of 25-50 exons) ACADVL (acyl- CoA dehydrogenase, very long chain) (eg, very long chain acyl-coenzyme A dehydrogenase deficiency), full gene sequence ACTN4 (actinin, alpha 4) (eg, focal segmental glomerulosclerosis), full gene sequence ACT04 (actinin, alpha 4) (eg, focal like 2 (S. cerevisiae)) (eg, spinocerebellar ataxia), full gene sequence AIRE (autoimmune regulator) (eg, autoimmune polyendocrinopathy syndrome type 1), full gene sequence ALDH7A1 (aldeh	Prior authorization is required.		
81407	Molecular pathology procedure, Level 8 (eg, analysis of 26-50 exons by DNA sequence analysis, mutation scanning or duplication/deletion variants of >50 exons, sequence analysis of multiple genes on one platform) ABCC8 (ATP-binding cassette, sub-family C [CFTR/MRP], member 8) (eg, familial hyperinsulinism), full gene sequence AGL (amylo- alpha-1, 6-glucosidase, d-alpha-glucanotransferase) (eg, glycogen storage disease type III), full gene sequence AH1 (Abelson helper integration site 1) (eg, Joubert syndrome), full gene sequence APOB (apolipoprotein 8) (eg, familial hypercholesterolemia type B)	Prior authorization is required.		
81408	Molecular pathology procedure, Level 9 (eg, analysis of >50 exons in a single gene by DNA sequence analysis) ABCA4 (ATP-binding cassette, sub-family A [ABC1], member 4) (eg, Stargardt disease, age-related macular degeneration), full gene sequence ATM (ataxia telangiectasia mutated) (eg, ataxia telangiectasia), full gene sequence CDH23 (cahderin- related 23) (eg, Usher syndrome, hype 1], full gene sequence CP209 (centrosomal protein 290kDa) (eg, Joubert syndrome), full gene sequence COL1A1 (collagen, type I, alpha 1) (eg, osteogenesis imperfecta, type 1), full gene sequence COL1A2 (collagen, ty	Prior authorization is required.		
81410	Acrtic 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 FBNJ, TGFBRJ, TGFBRZ, COL3A1, MYH11, ACTA2, SLC2A10, SMAD3 and MYLK	Prior authorization is required.		
81411	Aortic dysfunction or dilation (eg, Marfan syndrome, Loeys Dietz syndrome, Ehler Danlos syndrome type IV, arterial tortuosity syndrome); duplication/deletion analysis panel, must include analyses for TGFBR1, TGFBR2, MYH11 and COL3A1	Prior authorization is required.		
81412	Ashkenazi Jewish associated disorders (e.g. 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, GA, HEXA, IKBKAP, MCOLM1 and SMPD1	Prior authorization is required.		
81413	Cardiac ion channelopathies (eg. Brugada syndrome, long QT syndrome, short QT syndrome, catecholaminergic polymorphic ventricular tachycardia); genomic sequence analysis panel, must include sequencing of at least 10 genes, including ANK2, CASQ2, CAV3, KCNE1, KCNE2, KCNH2, KCNU2, KCNQ1, RYR2 and SCN5A	Prior authorization is required.		
81414	Cardiac ion channelopathies (eg, Brugada syndrome, long QT syndrome, short QT syndrome, catecholaminergic polymorphic ventricular tachycardia); duplication/deletion gene analysis panel, must include analysis of at least 2 genes, including KCNH2 and KCNQ1	Prior authorization is required.		
81415	Exome (eg, unexplained constitutional or heritable disorder or syndrome); sequence analysis	Prior authorization is required.		
81416	Exome (eg, unexplained constitutional or neritable disorder or syndrome); sequence analysis, each comparator exome (eg, parents, siblings) (List separately in addition to code for primary procedure)	Prior authorization is required.		
81417	Exome (eg, unexplained constitutional or heritable disorder or syndrome); re-evaluation of previously obtained exome sequence (eg, updated knowledge or unrelated condition/syndrome)	Prior authorization is required.		
81419	Epilepsy genomic sequence analysis panel, must include analyses for ALDH7A1, CACNA1A, CDKL5, CHD2, GABRG2, GRIN2A, KCNQ2, MECP2, PCDH19, POLG, PRRT2, SCN1A, SCN1B, SCN2A, SCNBA, SLC2A1, SLC9A6, STXBP1, SYNGAP1, TCF4, TPP1, TSC1, TSC2 and ZEB2	Prior authorization is required.		
81420	Fetal chromosomal aneuploidy (eg, trisomy 21, monosomy X) genomic sequence analysis panel, circulating cell-free fetal DNA in maternal blood, must include analysis of chromosomes 13, 18 and 21	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1208 Fetal Aneuploidy Testing Using Noninvasive Cell-Free Fetal DNA	
81422	Fetal chromosomal microdeletion(s) genomic sequence analysis (eg, DiGeorge syndrome, Cri-du-chat syndrome), circulating cell-free fetal DNA in maternal blood	Prior authorization is required.		
81425	Genome (eg, unexplained constitutional or heritable disorder or syndrome); sequence analysis	Prior authorization is required.		
81426	Genome (eg, unexplained constitutional or heritable disorder or syndrome); sequence analysis, each comparator genome (eg, parents, siblings) (List separately in addition to code for primary procedure)	Prior authorization is required.		
81427	Genome (eg, unexplained constitutional or heritable disorder or syndrome); re-evaluation of previously obtained genome sequence (eg, updated knowledge or unrelated condition/syndrome)	Prior authorization is required.		
81430	Hearing loss (eg, nonsyndromic hearing loss, Usher syndrome, Pendred syndrome); genomic sequence analysis panel, must include sequencing of at least 60 genes, including CDH23, CLRNI, GIB2, GPR98, MTNNIA, MYO7A, MYO15A, PCDH15, OTOF, SLC26A4, TMC1, TMPRS53, USH1C, USH16, USH2A and WFS1	Prior authorization is required.		

	Hearing loss (eg, nonsyndromic hearing loss, Usher syndrome, Pendred syndrome);		
81431	duplication/deletion analysis panel, must include copy number analyses for STRC and DFNB1 deletions in GJB2 and GJB6 genes	Prior authorization is required.	
	Hereditary breast cancer-related disorders (eg, hereditary breast cancer, hereditary		
81432	ovarian cancer, hereditary endometrial cancer); genomic sequence analysis panel, must	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1210 Oncologic Genetic Testing Panels
	include sequencing of at least 10 genes, always including BRCA1, BRCA2, CDH1, MLH1, MSH2, MSH6, PALB2, PTEN, STK11 and TP53	· ·	
	Hereditary breast cancer-related disorders (eg, hereditary breast cancer, hereditary		
81433	ovarian cancer, hereditary endometrial cancer); duplication/deletion analysis panel, must	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1210 Oncologic Genetic Testing Panels
	include analyses for BRCA1, BRCA2, MLH1, MSH2 and STK11 Hereditary retinal disorders (eg, retinitis pigmentosa, Leber congenital amaurosis, cone-rod		
	dystrophy), genomic sequence analysis panel, must include sequencing of at least 15		
81434	genes, including ABCA4, CNGA1, CRB1, EYS, PDE6A, PDE6B, PRPF31, PRPH2, RDH12, RHO,	Prior authorization is required.	
	RP1, RP2, RPE65, RPGR and USH2A		
	Hereditary colon cancer disorders (eg, Lynch syndrome, PTEN hamartoma syndrome, Cowden syndrome, familial adenomatosis polyposis); genomic sequence analysis panel,		
81435	must include sequencing of at least 10 genes, including APC, BMPR1A, CDH1, MLH1, MSH2,	Prior authorization is required.	
	MSH6, MUTYH, PTEN, SMAD4 and STK11		
	Hereditary colon cancer disorders (eg, Lynch syndrome, PTEN hamartoma syndrome, Cowden syndrome, familial adenomatosis polyposis); duplication/deletion analysis panel,		
81436	must include analysis of at least 5 genes, including MLH1, MSH2, EPCAM, SMAD4 and	Prior authorization is required.	
	STK11		
	Hereditary neuroendocrine tumor disorders (eg, medullary thyroid carcinoma, parathyroid carcinoma, malignant pheochromocytoma or paraganglioma); genomic sequence analysis		
81437	panel, must include sequencing of at least 6 genes, including MAX, SDHB, SDHC, SDHD,	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1210 Oncologic Genetic Testing Panels
	TMEM127 and VHL		
	Hereditary neuroendocrine tumor disorders (eg, medullary thyroid carcinoma, parathyroid		
81438	carcinoma, malignant pheochromocytoma or paraganglioma); duplication/deletion	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1210 Oncologic Genetic Testing Panels
	analysis panel, must include analyses for SDHB, SDHC, SDHD and VHL		
	Hereditary cardiomyopathy (eg, hypertrophic cardiomyopathy, dilated cardiomyopathy,		
81439	arrhythmogenic right ventricular cardiomyopathy), genomic sequence analysis panel, must include sequencing of at least 5 cardiomyopathy-related genes (eg, DSG2, MYBPC3, MYH7,	Prior authorization is required.	
	PKP2, TTN)		
	Nuclear encoded mitochondrial genes (eg, neurologic or myopathic phenotypes), genomic		
81440	sequence panel, must include analysis of at least 100 genes, including BCS1L, C10orf2, COQ2, COX10, DGUOK, MPV17, OPA1, PDSS2, POLG, POLG2, RRM2B, SCO1, SCO2,	Prior authorization is required.	
	SLC25A4, SUCLA2, SUCLG1, TAZ, TK2 and TYMP		
	Noonan spectrum disorders (eg, Noonan syndrome, cardio-facio-cutaneous syndrome,		
81442	Costello syndrome, LEOPARD syndrome, Noonan-like syndrome), genomic sequence analysis panel, must include sequencing of at least 12 genes, including BRAF, CBL, HRAS,	Prior authorization is required.	
	KRAS, MAP2K1, MAP2K2, NRAS, PTPN11, RAF1, RIT1, SHOC2 and SOS1		
	Genetic testing for severe inherited conditions (eg, cystic fibrosis, Ashkenazi Jewish-		
	associated disorders [eg, Bloom syndrome, Canavan disease, Fanconi anemia type C,		
81443	mucolipidosis type VI, Gaucher disease, Tay-Sachs disease], beta hemoglobinopathies,	Prior authorization is required.	
	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)		
	Solid organ neoplasm, genomic sequence analysis panel, 5-50 genes, interrogation for		
81445	sequence variants and copy number variants or rearrangements, if performed; DNA	Prior authorization is required.	
	analysis or combined DNA and RNA analysis Hereditary peripheral neuropathies (eg, Charcot-Marie-Tooth, spastic paraplegia), genomic		
81448	sequence analysis panel, must include sequencing of at least 5 peripheral neuropathy-	Prior authorization is required.	
	related genes (eg, BSCL2, GJB1, MFN2, MPZ, REEP1, SPAST, SPG11, SPTLC1)	•	
	Hematolymphoid neoplasm or disorder, genomic sequence analysis panel, 5-50 genes,		
81450	interrogation for sequence variants, and copy number variants or rearrangements, or isoform expression or mRNA expression levels, if performed; DNA analysis or combined	Prior authorization is required.	
	DNA and RNA analysis		
	Solid organ or hematolymphoid neoplasm or disorder, 51 or greater genes, genomic		
81455	sequence analysis panel, interrogation for sequence variants and copy number variants or rearrangements, or isoform expression or mRNA expression levels, if performed; DNA	Prior authorization is required.	
	analysis or combined DNA and RNA analysis		
	Whole mitochondrial genome (eg, Leigh syndrome, mitochondrial encephalomy opathy,		
81460	lactic acidosis and stroke-like episodes [MELAS], myoclonic epilepsy with ragged-red fibers [MERFF], neuropathy, ataxia and retinitis pigmentosa [NARP], Leber hereditary optic	Prior authorization is required.	
01400	neuropathy [LHON]), genomic sequence, must include sequence analysis of entire	. nor demonitation is required.	
	mitochondrial genome with heteroplasmy detection		
81465	Whole mitochondrial genome large deletion analysis panel (eg, Kearns-Sayre syndrome, chronic progressive external ophthalmoplegia), including heteroplasmy detection, if	Prior authorization is required.	
01400	chronic progressive external ophthalmoplegia), including neteroplasmy detection, if performed	ritor authorization is required.	
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	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,			
81470	ATRX, CDKL5, FGD1, FMR1, HUWE1, IL1RAPL, KDM5C, L1CAM, MECP2, MED12, MID1,	Prior authorization is required.		
	OCRL, RPS6KA3 and SLC16A2			
	X-linked intellectual disability (XLID) (eg, syndromic and non-syndromic XLID);			
	duplication/deletion gene analysis, must include analysis of at least 60 genes, including			
81471	ARX, ATRX, CDKL5, FGD1, FMR1, HUWE1, IL1RAPL, KDM5C, L1CAM, MECP2, MED12,	Prior authorization is required.		
	MID1, OCRL, RPS6KA3 and SLC16A2			
			HHO-DE-MP-1210 Oncologic Genetic Testing Panels and HHO-	
81479	Unlisted molecular pathology procedure	Prior authorization is required. Reference policies for additional information.	DE-MP-1250 BRCA1 & BRCA2 Genetic Mutation Testing and	
014/9	Unisted molecular pathology procedure	Phor autionzation is required. Reference policies for additional information.	Related Genetic Counseling	
			Related Genetic Counseiing	
81490	Autoimmune (rheumatoid arthritis), analysis of 12 biomarkers using immunoassays,	Prior authorization is required.		
	utilizing serum, prognostic algorithm reported as a disease activity score			
81493	Coronary artery disease, mRNA, gene expression profiling by real-time RT-PCR of 23 genes,	Prior authorization is required.		
	utilizing whole peripheral blood, algorithm reported as a risk score	· · · · · · · · · · · · · · · · · · ·		
81500	Oncology (ovarian), biochemical assays of two proteins (CA-125 and HE4), utilizing serum,	Prior authorization is required.		
	with menopausal status, algorithm reported as a risk score	· · · · · · · · · · · · · · · · · · ·		
	Oncology (ovarian), biochemical assays of five proteins (CA-125, apolipoprotein A1, beta-2			
81503	microglobulin, transferrin and pre-albumin), utilizing serum, algorithm reported as a risk	Prior authorization is required.		
	score			
	Oncology (tissue of origin), microarray gene expression profiling of > 2000 genes, utilizing			
81504		Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1210 Oncologic Genetic Testing Panels	
	formalin-fixed paraffin-embedded tissue, algorithm reported as tissue similarity scores			
	Endocrinology (type 2 diabetes), biochemical assays of seven analytes (glucose, HbA1c,			
81506	insulin, hs-CRP, adiponectin, ferritin, interleukin 2-receptor alpha), utilizing serum or plasma,	Prior authorization is required.		
	algorithm reporting a risk score			
04507	Fetal aneuploidy (trisomy 21, 18 and 13) DNA sequence analysis of selected regions using		HHO-DE-MP-1208 Fetal Aneuploidy Testing Using Noninvasive	
81507	maternal plasma, algorithm reported as a risk score for each trisomy	Prior authorization is required. Reference policies for additional information.	Cell-Free Fetal DNA	
	Fetal congenital abnormalities, biochemical assays of two proteins (PAPP-A, hCG [any			
81508	form]), utilizing maternal serum, algorithm reported as a risk score	Prior authorization is required.		
	Fetal congenital abnormalities, biochemical assays of three proteins (PAPP-A, hCG [any			
81509	form], DIA), utilizing maternal serum, algorithm reported as a risk score	Prior authorization is required.		
	Fetal congenital abnormalities, biochemical assays of three analytes (AFP, uE3, hCG [any			
81510	form]), utilizing maternal serum, algorithm reported as a risk score	Prior authorization is required.		
	Fetal congenital abnormalities, biochemical assays of four analytes (AFP, uE3, hCG [any			
81511	form], DIA) utilizing maternal serum, algorithm reported as a risk score (may include	Prior authorization is required.		
01011	additional results from previous biochemical testing)	The automation stepared.		
	Fetal congenital abnormalities, biochemical assays of five analytes (AFP, uE3, total hCG,			
81512	hyperglycosylated hCG, DIA) utilizing maternal serum, algorithm reported as a risk score	Prior authorization is required.		
	hypergrycosylated ned, or A) dulizing matemariserum, algorithm reported as a risk score			
	Infectious disease, bacterial vaginosis, quantitative real-time amplification of RNA markers			
81513	for Atopobium vaginae, Gardnerella vaginalis and Lactobacillus species, utilizing vaginal-	Prior authorization is required.		
	fluid specimens, algorithm reported as a positive or negative result for bacterial vaginosis			
	Infectious disease, bacterial vaginosis and vaginitis, quantitative real-time amplification of			
	DNA markers for Gardnerella vaginalis, Atopobium vaginae, Megasphaera type 1,			
	Bacterial Vaginosis Associated Bacteria-2 (BVAB-2) and Lactobacillus species (L. crispatus			
81514	and L. jensenii), utilizing vaginal-fluid specimens, algorithm reported as a positive or	Prior authorization is required.		
	negative for high likelihood of bacterial vaginosis, includes separate detection of			
	Trichomonas vaginalis and/or Candida species (C. albicans, C. tropicalis, C. parapsilosis, C.			
	dubliniensis), Candida glabrata, Candida krusei, when reported			
	Oncology (breast), mRNA, gene expression profiling by real-time RT-PCR of 11 genes (7			
81518	content and 4 housekeeping), utilizing formalin-fixed paraffin-embedded tissue, algorithms	Prior authorization is required.		
01010	reported as percentage risk for metastatic recurrence and likelihood of benefit from	The automation brequired.		
	extended endocrine therapy			
	Oncology (breast), mRNA, gene expression profiling by real-time RT-PCR of 21 genes,			
81519	utilizing formalin-fixed paraffin-embedded tissue, algorithm reported as recurrence score	Prior authorization is required.		
	demang ronnamentaed paraminerindedded dssue, algonunin reported as recurrence score			
	Oncology (breast), mRNA gene expression profiling by hybrid capture of 58 genes (50			
81520	content and 8 housekeeping), utilizing formalin-fixed paraffin-embedded tissue, algorithm	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1210 Oncologic Genetic Testing Panels	
	reported as a recurrence risk score	· ·	- •	
	Oncology (breast), mRNA, microarray gene expression profiling of 70 content genes and			
			HHO-DE-MP-1210 Oncologic Genetic Testing Panels	
81521	465 housekeeping genes, utilizing fresh frozen or formalin-fixed paraffin-embedded tissue,	Prior authorization is required. Reference policies for additional information.		
81521	465 housekeeping genes, utilizing fresh frozen or formalin-fixed paraffin-embedded tissue,	Prior authorization is required. Reference policies for additional information.		
81521	465 housekeeping genes, utilizing fresh frozen or formalin-fixed paraffin-embedded tissue, algorithm reported as index related to risk of distant metastasis	Prior authorization is required. Reference policies for additional information.		
	465 housekeeping genes, utilizing fresh frozen or formalin-fixed paraffin-embedded tissue, algorithm reported as index related to risk of distant metastasis Oncology (breast), mRNA, gene expression profiling by RT-PCR of 12 genes (8 content and			
81521 81522	465 housekeeping genes, utilizing fresh frozen or formalin-fixed paraffin-embedded tissue, algorithm reported as index related to risk of distant metastasis 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	Prior authorization is required. Reference policies for additional information. Prior authorization is required.		
	465 housekeeping genes, utilizing fresh frozen or formalin-fixed paraffin-embedded tissue, algorithm reported as index related to risk of distant metastasis 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			
81522	465 housekeeping genes, utilizing fresh frozen or formalin-fixed paraffin-embedded tissue, algorithm reported as index related to risk of distant metastasis 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 Oncology (breast), mRNA, next-generation sequencing gene expression profiling of 70	Prior authorization is required.		
	465 housekeeping genes, utilizing fresh frozen or formalin-fixed paraffin-embedded tissue, algorithm reported as index related to risk of distant metastasis Oncology (breast), mRNA, gene expression profiling by RT-RC of 12 genes (8 content and 4 housekeeping), utilizing formalin-fixed paraffin-embedded tissue, algorithm reported as recurrence risk score Oncology (breast), mRNA, next-generation sequencing gene expression profiling of 70 content genes and 31 housekeeping genes, utilizing formalin-fixed paraffin-embedded			
81522	465 housekeeping genes, utilizing fresh frozen or formalin-fixed paraffin-embedded tissue, algorithm reported as index related to risk of distant metastasis 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 Oncology (breast), mRNA, next-generation sequencing gene expression profiling of 70 content genes and 31 housekeeping genes, utilizing formalin-fixed paraffin-embedded tissue, algorithm reported as index related to risk to distant metastasis	Prior authorization is required.		
81522 81523	465 housek eeping genes, utilizing fresh frozen or formalin-fixed paraffin-embedded tissue, algorithm reported as index related to risk of distant metastasis Oncology (toreast), 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 Concology (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 Oncology (colon), mRNA, gene expression profiling to PT content genes (8 content and 9 content genes), utilizing formalin-fixed paraffin-embedded tissue, algorithm reported as index related to risk to distant metastasis	Prior authorization is required. Prior authorization is required.		
81522	465 housekeeping genes, utilizing fresh frozen or formalin-fixed paraffin-embedded tissue, algorithm reported as index related to risk of distant metastasis 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 Oncology (breast), mRNA, next-generation sequencing gene expression profiling of 70 content genes and 31 housekeeping genes, utilizing formalin-fixed paraffin-embedded tissue, algorithm reported as index related to risk to distant metastasis	Prior authorization is required.		

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81339 additional single drug or drug combination (Ust separately in addition to code for primary procedure) Prior authorization is required. 81538 Oncology (lung), mass spectrometric 8-protein signature, including amyloid A, utilizing serum, progenotic and predictive algorithm reported as good versus poor overal survival Prior authorization is required. 81538 Oncology (heyrade prostate cancer), biochemical assay of four proteins (Total PSA, Free algorithm reported as a probability score Prior authorization is required. 01 01 algorithm reported as a probability score Prior authorization is required. 01 01 algorithm reported as a probability score Prior authorization is required. 01 01 algorithm reported as a probability score Prior authorization is required. 01 01 algorithm reported as a probability of a predicted main cancer type and subtype, utilizing formalin-freed parifine-medded tissue, algorithm reported as a probability of a predicted main cancer type and subtype (unstruct MRM, gene expression profiling by trasi-line RT-PCR of 45 genes (31 content and 15 housekeeping), utilizing formalin-freed parifine-medded tissue, algorithm reported as a lobability of a predicted main cancer type and subtype (utilizing formalin-free parifine algorithm reported as a lobability of a predicted main cancer type and subtype (utilizing formalin-free parifine algorithm reported as a lobability of a predicted main cancer type and subtype (utilizing formalin-free parifine medded tissue, algorithm reported as a lobability of a predicted main cancer type and subtype (utilizing formalin-free parifine medded tissue, algorithm reporte
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81338 serum, prognostic and predictive algorithm reported as good versus poor overall survival Prior authorization is required. 81539 Oncology (high-grade prostate cancer), biochemical assay of four proteins (Total PSA, Free BSA, Intact PSA and human kalikricer) algorithm reported as a probability score Prior authorization is required. 0ncology (hum or dunknown oligin), mRNA, gene expression profiling by real-time RT-PCR subtrye, utilizing formalin-fixed paraffine-mbedded tissue, algorithm reported as probability of a predictime reported as to probability score Prior authorization is required. Reference policies for additional information. HHO-DE-MP-1210 Oncologic Genetic Testing Panels 81540 Oncology (prostate), mRNA gene expression profiling by real-time RT-PCR of 46 genes [31 content and 15 housekeeping), utilizing tormali-fixed paraffine-mbedded tissue, algorithm reported as probability of a prediction and smorter ype and subtrye, utilizing formalin-fixed paraffine-mbedded tissue, algorithm reported as probability of a prediction and smorter ype and probability of a prediction and predictin and prediction and prediction and pre
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81539 P5A, Intact P5A and human kallkreine? [NC2]), utilizing plasma or serum, prognostic algorithm reported as a probability score oncology (uturon of unknown origin), mRNA, gene expression profiling by real-time RT-PCR of 92 genes (87 content and 5 housekeeping), utilizing formal-in-fixed paraffin-embedded tissue, algorithm reported as a subtype, utilizing formal-in-fixed paraffin-embedded tissue, algorithm reported as a subtype. utilizing formal-in-fixed paraffin-embedded tissue, algorithm reported as a subtype. utilizing formal-in-fixed paraffin-embedded tissue, algorithm reported as a note that al 51 shousekeeping). utilizing formal-in-fixed paraffin-embedded tissue, algorithm reported as a disease-specific motality risk score reported as a disease-specific mot
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81540 Oncology (tumor of unknown origin), mRNA, gene expression profiling by real-time RT-PCR of 92 genes (87 content and 5 housekeeping) to classify tumor into main cancer type and subtype, utilizing formalin-fixed paraffin-mebded tissue, algorithm reported as a probability of a predicted main cancer type and subtype, utilizing formalin-fixed paraffin-mebded tissue, algorithm reported as a probability of a predicted main cancer type and subtype, utilizing formalin-fixed paraffin-mebded tissue, algorithm reported as a desease-specific mortality risk score reposing profiling by real-time RT-PCR of 46 genes (31 content and 5 housekeeping), utilizing formalin-fixed paraffin-embedded tissue, algorithm reported as a desease-specific mortality risk score utilizing formalin-fixed paraffin-embedded tissue, algorithm reported as metastasis risk score score utilizing formalin-fixed paraffin-embedded tissue, algorithm reported as metastasis risk score utilizing formalin-fixed paraffin-embedded tissue, algorithm reported as a categorical result (eg, benging or suspicious) Prior authorization is required. Reference policies for additional information. HHO-DE-MP-1210 Oncologic Genetic Testing Panels 81542 Oncology (prostate), mRNA, gene expression profiling of 22 content genes, utilizing formalin-fixed paraffin-embedded tissue, algorithm reported as a categorical result (eg, benging or suspicious) Prior authorization is required. HHO-DE-MP-1210 Oncologic Genetic Testing Panels 81542 Oncology (prostate), mRNA, gene expression profiling of 22 content genes, utilizing finan nepoted as a categorical result (eg, benging or suspicious) Prior authorization is required. HHO-DE-MP-1210 Oncologic Genetic Testing Panels 81546 Oncology (prostate), monoter met
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81540 subtype, utilizing formalin-fixed paraffin-embedded tissue, algorithm reported as a probability of a predicted main cancer type and subtype Prior authorization is required. Reference policies for additional information. HHO-DE-MP-1210 Oncologic Genetic Testing Panels 81541 Oncology (prostel), mRNA gene expression profiling by real-time RT-PCR of 5 genes (31 content and 15 housekeeping), utilizing formalin-fixed paraffin-embedded tissue, algorithm reported as a diseas-specific mortality risk score Prior authorization is required. Reference policies for additional information. HHO-DE-MP-1210 Oncologic Genetic Testing Panels 81542 Oncology (prostel), mRNA, gene expression profiling of 22 content genes, utilizing formalin-fixed paraffin-embedded tissue, algorithm reported as a dateage-specific mortality risk score Prior authorization is required. HHO-DE-MP-1210 Oncologic Genetic Testing Panels 81542 Oncology (prostat), mRNA, gene expression profiling of 22 content genes, utilizing fine needle aspirate of portal data datages (SFT) appendixed, algorithm reported as a datages (SFT) appendixed, algorithm reported as a datagenes (SFT) appendixed, algorithm reported as a categorical result (eg. being or suspicious) Prior authorization is required. 81551 Oncology (usedan), mRNA, gene expression profiling by real-time PCR of 15 genes (STT) appendixed and information is required. Prior authorization is required. 81552 Oncology (usedan man), mRNA, gene expression profiling by real-time FCR of 15 genes (STT) appendixed appendix peral-time profiling by real-time FCR of 15 genes (STT) appendixed appendixed appendixed paraffin-embedded tisse, algorithm reported as a prior authorization is r
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81541 content and 15 housekeeping), utilizing formalin-fixed paraffin-embedded tissue, algorithm reported as a disease-specific mortality, risk score Prior authorization is required. Reference policies for additional information. HHO-DE-MP-1210 Oncologic Genetic Testing Panels 81542 Oncology (prostate), mRNA, microarray gene expression profiling of 22 content genes, score Prior authorization is required. Prior authorization is required. 81542 Oncology (throid), mRNA, gene expression analysis of 10,196 genes, utilizing fine meedde aspirate, algorithm reported as a categorical result (eg. bengo or suspicious) Prior authorization is required. Prior authorization is required. 81542 Oncology (throid), mRNA, gene expression analysis of 10,196 genes, utilizing fine meedde aspirate, algorithm reported as a categorical result (eg. bengo or suspicious) Prior authorization is required. Prior authorization is required. 81551 Oncology (throid), mRNA, gene expression 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 biogy Prior authorization is required. Prior authorization is required. 81552 genes (12 content and 3 housekeeping), utilizing fine needed aspirate or formalin-fixed Prior authorization is required. Prior authorization is required.
81541 content and 15 housekeeping), utilizing formalin-fixed paraffin-embedded tissue, algorithm reported as a disease-specific mortality, risk score Prior authorization is required. Reference policies for additional information. HHO-DE-MP-1210 Oncologic Genetic Testing Panels 81542 Oncology (prostate), mRNA, microarray gene expression profiling of 22 content genes, utilizing formalin-fixed paraffin-embedded tissue, algorithm reported as metastasis risk score Prior authorization is required. HHO-DE-MP-1210 Oncologic Genetic Testing Panels 81542 Oncology (thyroid), mRNA, microarray gene expression profiling of 22 content genes, score Prior authorization is required. Image: main fixed paraffin-embedded tissue, algorithm reported as metastasis risk score Prior authorization is required. Image: main fixed paraffin-embedded tissue, algorithm reported as a categorical result (eg. beng or suspicious) Prior authorization is required. Image: main fixed paraffin-embedded tissue, algorithm reported as a metabolicous of prostate cancer detection on repeat biopsy Prior authorization is required. Image: main fixed paraffin-embedded tissue, algorithm reported as a metabolicous of prostate cancer detection on repeat biopsy Prior authorization is required. Image: main fixed paraffin-embedded tissue, algorithm reported as a metabolicous of prostate cancer detection on repeat biopsy Prior authorization is required. Image: main fixed paraffin-embedded tissue, algorithm reported as a metabolicous of prostate cancer detection on repeat biopsy Prior authorization is required. Image: main fixed paraffin-embedded tissue, algorith
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81542 utilizing formalin-fixed paraffin-embedded tissue, algorithm reported as metastasis risk score Prior authorization is required. 81546 Oncology (thyroid), mRNA, gene expression analysis of 10,196 genes, utilizing fine needle as parate, algorithm reported as a categorical result (eg. benign or suspicious) Prior authorization is required. 81551 Oncology (thyroid), mRNA, gene expression analysis of 10,196 genes, utilizing fine needle dissue, algorithm reported as a categorical result (eg. benign or suspicious) Prior authorization is required. 81551 Oncology (prostate), promoter methylation profiling by real-time PCR of 3 genes (GSTP1, APC, RASSF1), utilizing formalin-fixed paraffin-embedded tissue, algorithm reported as a likelihood of prostate cancer detection on repeat biopsy Prior authorization is required. 0ncology (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 Prior authorization is required. 81552 genes (12 content and 3 housekeeping), utilizing fine needle aspirate or formalin-fixed Prior authorization is required.
81542 utilizing formalin-fixed paraffin-embedded tissue, algorithm reported as metastasis risk score Prior authorization is required. 81546 Oncology (thyroid), mRNA, gene expression analysis of 10,16g genes, utilizing fine needle aspirate, algorithm reported as a categorical result (e.g. benign or suspicious) Prior authorization is required. 81551 Oncology (thyroid), mRNA, gene expression analysis of 10,16g genes, utilizing fine needle Prior authorization is required. 81551 Oncology (prostate), promoter methylation profiling by real-time PCR of 3 genes (GSTP1, APC, RASSF1), utilizing formalin-fixed paraffin-embedded tissue, algorithm reported as a likelihood of prostate cancer detection on repeat biopsy Prior authorization is required. 81552 genes (12 content and 3 housekeeping), utilizing fine needle aspirate or formalin-fixed Prior authorization is required.
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81551 APC, RASSF1), utilizing formalin-fixed paraffin-embedded tissue, algorithm reported as a likelihood of prostate cancer detection on repeat biopsy Prior authorization is required. 0ncology (uveal melanoma), mRNA, gene expression profiling by real-time RT-PCR of 15 genes (12 content and 3 housekeeping), utilizing fine needie aspirate or formalin-fixed Prior authorization is required.
81551 APC, RASSF1), utilizing formalin-fixed paraffin-embedded tissue, algorithm reported as a likelihood of prostate cancer detection on repeat biopsy Prior authorization is required. 0ncology (uveal melanoma), mRNA, gene expression profiling by real-time RT-PCR of 15 genes (12 content and 3 housekeeping), utilizing fine needie aspirate or formalin-fixed Prior authorization is required.
Inkelihood of prostate cancer detection on repeat biopsy 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
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 Prior authorization is required.
81552 genes (12 content and 3 housekeeping), utilizing fine needle aspirate or formalin-fixed Prior authorization is required.
paramin-embedded ussde, algonum reported as risk of metastasis
Pulmonary disease (idiopathic pulmonary fibrosis [IPF]), mRNA, gene expression analysis
81554 of 190 genes, utilizing transbronchial biopsies, diagnostic algorithm reported as categorical Prior authorization is required.
result (eg, positive or negative for high probability of usual interstitial pneumonia [UIP])
Cardiology (heart transplant), mRNA, gene expression profiling by real-time quantitative
81595 PCR of 20 genes (11 content and 9 housekeeping), utilizing subfraction of peripheral blood, Prior authorization is required.
algorithm reported as a rejection risk score
agonomic porce as a rejection risk score
Infectious disease, chronic hepatitis C virus (HCV) infection, six biochemical assays (ALT, A2
81596 macroglobulin, apolipoprotein A-1, total bilirubin, GGT and haptoglobin) utilizing serum, Prior authorization is required.
prognostic algorithm reported as scores for fibrosis and necroinflammatory activity in liver
81599 Unlisted multianalyte assay with algotithmic analysis procedure Prior authorization is required.
Blood, occult, by perovidase activity (eg, guaiac), qualitative; feces, consecutive collected Prior authorization is required for members under the age of 45. Reference policies for additional
82270 specimens with single determination, for colorectal neoplasm screening (ie, patient was information.
provided 3 cards or single triple card for consecutive collection)
Pland accult by approvide a activity (or guarda) analistics faces 1.2 circultaneous Prior authorization is required for members under the area of 45. Petersone policies for additional
determinations, performed for other than colorectal neoplasm screening INTORMATION.
82274 Blood, occult by fecal hemoglobin determination by immunoassay, qualitative, feces, 1-3 Prior authorization is required for members under the age of 45. Reference policies for additional HHO-DE-MP-1007 Colorectal Cancer Screening
82274 blob, coally by recommingious determinations and public receives a station received on memory and the received on the re
82523 Collagen cross links, any method Prior authorization is required.
82607 Cyanocobalamin (Vitamin B-12); Prior authorization is required.
82608 Cyanocobalamin (Vitamin B-12); unsaturated binding capacity Prior authorization is required.
82955 Glucose-6 photos and a second s
83090 Homocysteine Prior authorization is required.
83937 Osteocalcin (bone g1a protein) Prior authorization is required.
X/UXU Vhochbatase alkaline: isoanzimes Prior authorization is required
84080 Phosphatase, alkaline; isoenzymes Prior authorization is required.
84431 Thromboxane metabolite(s), including thromboxane if performed, urine Prior authorization is required. Reference policies for additional information. HHO-DE-MP-1002 Pharmacogenomic Testing
84431 Thromboxane metabolite(s), including thromboxane if performed, urine Prior authorization is required. Reference policies for additional information. HHO-DE-MP-1002 Pharmacogenomic Testing 84591 Pathology test Prior authorization is required. Prior authorization is required.
84431 Thromboxane metabolit(s), including thromboxane if performed, urine Prior authorization is required. Reference policies for additional information. HHO-DE-MP-1002 Pharmacogenomic Testing 84591 Pathology test One of the prior authorization is required. One of the prior authorization is required. 84599 Unlisted chemistry procedure Prior authorization is required for not otherwise classified codes.
84431 Thromboxane metabolite(s), including thromboxane if performed, urine Prior authorization is required. Reference policies for additional information. HHO-DE-MP-1002 Pharmacogenomic Testing 84591 Pathology test Prior authorization is required. Median is required. 84999 Unlisted chemistry procedure Prior authorization is required for not otherwise classified codes. Median is required. 85999 Unlisted hematology procedure Prior authorization is required. Median is required.
84431 Thromboxane metabolite(s), induding thromboxane if performed, urine Prior authorization is required. Reference policies for additional information. HHO-DE-MP-1002 Pharmacogenomic Testing 84591 Pathology test Prior authorization is required. Prior authorization is required. 84999 Unlisted chemistry procedure Prior authorization is required for not otherwise classified codes.
84431 Thromboxane metabolite(s), including thromboxane if performed, urine Prior authorization is required. Reference policies for additional information. HHO-DE-MP-1002 Pharmacogenomic Testing 84591 Pathology test Prior authorization is required. 84999 Unlisted chemistry procedure Prior authorization is required for not otherwise classified codes. 85999 Unlisted hematology procedure Prior authorization is required. 86849 Unlisted immunology procedure Prior authorization is required.
84431 Thromboxane metabolite(s), including thromboxane if performed, urine Prior authorization is required. Reference policies for additional information. HHO-DE-MP-1002 Pharmacogenomic Testing 84591 Pathology test Prior authorization is required. 84999 Unlisted chemistry procedure Prior authorization is required for not otherwise classified codes. 85999 Unlisted hematology procedure Prior authorization is required. 86849 Unlisted immunology procedure Prior authorization is required. 86999 Unlisted transfusion medicine procedure Prior authorization is required for not otherwise classified codes.
84431 Thromboxane metabolite(s), including thromboxane if performed, urine Prior authorization is required. Reference policies for additional information. HHO-DE-MP-1002 Pharmacogenomic Testing 84591 Pathology test Prior authorization is required. 84999 Unlisted chemistry procedure Prior authorization is required for not otherwise classified codes. 85999 Unlisted hematology procedure Prior authorization is required. 86849 Unlisted immunology procedure Prior authorization is required.

07655	Infectious agent antigen detection by immunoassay with direct optical (ie, visual)	A 1 1 1 1 1 1		
87899	observation; not otherwise specified	Prior authorization is required.		
87999	Unlisted microbiology procedure	Prior authorization is required for not otherwise classified codes.		
88160	Cytopathology, smears, any other source; screening and interpretation	Prior authorization is required for members under the age of 45. Reference policies for additional information.	HHO-DE-MP-1007 Colorectal Cancer Screening	
88199	Cytopathology	Prior authorization is required.		
		Prior authorization is required. Reference policies for additional information.		
88299	Unlisted cytogenetic study	Prior authorization is required for not otherwise classified codes.	HHO-DE-MP-1210 Oncologic Genetic Testing Panels	
88360	Morphometric analysis, tumor immunohistochemistry (eg, Her-2/neu, estrogen receptor/progesterone receptor), quantitative or semiquantitative, per specimen, each single antibody stain procedure; manual	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1002 Pharmacogenomic Testing and HHO-DE-MP- 1028 Molecular Tumor Markers for Non-Small Lung Cancer	
88361	Morphometric analysis, tumor immunohistochemistry (eg. Her-2/neu, estrogen receptor/progesterone receptor), quantitative or semiquantitative, per specimen, each single antibiody stain procedure; using computer-assisted technology	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1028 Molecular Tumor Markers for Non-Small Lung Cancer	
88399	Surgical pathology procedure	Prior authorization is required.		
88749	Pathology test	Prior authorization is required.		
89240	Unlisted pathology	Prior authorization is required.		
89398	Reproductive laboratory procedure	Prior authorization is required.		
90378	Respiratory syncytial virus, monoclonal antibody, recombinant, for IM use, 50 mg, each	Prior authorization is required.		
90399	Unlisted immune globulin	Prior authorization is required.		
90749	Unlisted vaccine	Prior authorization is required.		
90867	Therapeutic repetitive transcranial magnetic stimulation (TMS) treatment; initial, including cortical mapping, motor threshold determination, delivery and management	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1147 Transcranial Magnetic Stimulation (TMS)	
90868	Therapeutic repetitive transcranial magnetic stimulation (TMS) treatment; subsequent delivery and management, per session	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1147 Transcranial Magnetic Stimulation (TMS)	
90869	Therapeutic repetitive transcranial magnetic stimulation (TMS) treatment; subsequent motor threshold re-determination with delivery and management	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1147 Transcranial Magnetic Stimulation (TMS)	
90870	Electroconvulsive therapy (includes necessary monitoring)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1162 Electroconvulsive Therapy	
90899	Unlisted psychiatric service or procedure	Prior authorization is required.		
90912	Biofeedback training, perineal muscles, anorectal or urethral sphincter, including EMG and/or manometry, when performed; initial 15 minutes of one-on-one physician or other qualified health care professional contact with the patient	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1193 Biofeedback and HHO-DE-MP-1117 Urinary Incontinence Therapy	
90913	Biofeedback training, perineal muscles, anorectal or urethral sphincter, including EMG and/or manometry, when performed; each additional 12 minutes of one-on-one physician or other qualified health care professional contact with the patient (List separately in addition to code for primary procedure)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1193 Biofeedback and HHO-DE-MP-1117 Urinary Incontinence Therapy	
91034	Esophagus, gastroesophageal reflux test; with nasal catheter pH electrode(s) placement, recording, analysis and interpretation	Prior authorization is required.		
91035	Esophagus, gastroesophageal reflux test; with mucosal attached telemetry pH electrode placement, recording, analysis and interpretation	Prior authorization is required.		
91110	Gastrointestinal tract imaging, intraluminal (eg, capsule endoscopy), esophagus through ileum, with interpretation and report	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1005 Wireless Capsule Endoscopy as a Diagnostic Technique in Disorders of the Small Bowel, Esophagus and Colon	
91111	Gastrointestinal tract imaging, intraluminal (eg, capsule endoscopy), esophagus with interpretation and report	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1005 Wireless Capsule Endoscopy as a Diagnostic Technique in Disorders of the Small Bowel, Esophagus and Colon	
91113	Gastrointestinal tract imaging, intraluminal (eg, capsule endoscopy), colon, with interpretation and report	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1005 Wireless Capsule Endoscopy as a Diagnostic Technique in Disorders of the Small Bowel, Esophagus and Colon	
91200	Liver elastography, mechanically induced shear wave (eg, vibration), without imaging, with interpretation and report	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1014 Noninvasive Assessment of Liver Fibrosis in Chronic Hepatitis	
91299	Unlisted diagnostic gastroenterology procedure	Prior authorization is required for not otherwise classified codes. Reference policies for additional information.	HHO-DE-MP-1005 Wireless Capsule Endoscopy as a Diagnostic Technique in Disorders of the Small Bowel, Esophagus and Colon	
92002	Ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program; intermediate	Coverage is managed by Davis Vision		
92004	Ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program; comprehensive	Coverage is managed by Davis Vision		
92012	Ophthalmological services: medical examination and evaluation	Coverage is managed by Davis Vision		
92014	Ophthalmological services: medical examination and evaluation	Coverage is managed by Davis Vision		
92065	Orthoptic training; performed by a physician or other qualified health care professional	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1228 Vision Therapy	
92499	Unlisted ophthalmological service or procedure	Prior authorization is required.	····	
92507	Treatment of speech, language, voice, communication and/or auditory processing disorder: individual	Prior authorization is required. Prior authorization is required. Reference policies for additional information.	HHO-DE-RP-1013 Therapy Services	
92508	Treatment Of Speech, Language, Voice, Communication and/or Auditory Processing Disorder: Group. 2 Or More Individuals	Prior authorization is required. Reference policies for additional information.	HHO-DE-RP-1013 Therapy Services	
92512	Nasal Function Studies, Eg, Rhinomanometry	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1179 Rhinomanometry	
			HHO-DE-MP-1145 Cochlear Implants and HHO-DE-RP-1013	
92521	Evaluation of speech fluency (eg, stuttering, cluttering)	Prior authorization is required. Reference policies for additional information.	Therapy Services	

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

	Echocardiography, transthoracic, real-time with image documentation (2d), includes m-		Driez authorization is managed h
93306	mode recording, when performed, complete, with spectral doppler echocardiography and with color flow doppler echocardiography	Prior authorization is managed by EviCore.	Prior authorization is managed b EviCore.
93307	Echocardiography, transthoracic, real-time with image documentation (2d) with or without m-mode recording; complete	Prior authorization is managed by EviCore.	Prior authorization is managed b EviCore.
93308	Echocardiography, transthoracic, real-time with image documentation (2d) with or without m-mode recording; follow-up or limited study	Prior authorization is managed by EviCore.	Prior authorization is managed b EviCore.
93312	TEE 2D;Incl Probe Placement, Imaging/Interp/Report	Prior authorization is managed by EviCore.	Prior authorization is managed b EviCore.
93313	Echocardiography, transesophageal, real-time with image documentation (2D) (with or without M-mode recording); placement of transesophageal probe only	Prior authorization is managed by EviCore.	Prior authorization is managed b EviCore.
93314	Echocardiography, transesophageal, real-time with image documentation (2D) (with or without M-mode recording); image acquisition, interpretation and report only	Prior authorization is managed by EviCore.	Prior authorization is managed b EviCore.
93315	Transesophageal echocardiography for congenital cardiac anomalies; including probe placement, image acquisition, interpretation and report	Prior authorization is managed by EviCore.	Prior authorization is managed b EviCore.
93316	Transesophageal echocardiography for congenital cardiac anomalies; placement of transesophageal probe only	Prior authorization is managed by EviCore.	Prior authorization is managed b EviCore.
93317	Transesophageal echocardiography for congenital cardiac anomalies; image acquisition, interpretation and report only	Prior authorization is managed by EviCore.	Prior authorization is managed b EviCore.
93319	3D echocardiographic imaging and postprocessing during transesophageal echocardiography, or during transthoracic echocardiography for congenital cardiac anomalies, for the assessment of cardiac structure(s) (eg, cardiac chambers and valves, left atrial appendage, interatrial septum, interventricular septum) and function, when performed (List separately in addition to code for echocardiographic imaging	Prior authorization is managed by EviCore.	Prior authorization is managed b EviCore.
93320	Doppler echocardiography, pulsed wave and/or continuous wave with spectral display; complete	Prior authorization is managed by EviCore.	Prior authorization is managed b EviCore.
93321	Doppler echocardiography, pulsed wave and/or continuous wave with spectral display; follow-up or limited study	Prior authorization is managed by EviCore.	Prior authorization is managed b EviCore.
93325	Doppler echocardiography color flow velocity mapping	Prior authorization is managed by EviCore.	Prior authorization is managed b EviCore.
93350	Echocardiography, transthoracic, real-time with image documentation (2d), with or without m-mode recording, during rest and cardiovascular stress test, with interpretation and report	Prior authorization is managed by EviCore.	Prior authorization is managed b EviCore.
93351	Echocardiography, transthoracic, real-time with image documentation (2d), includes m- mode recording, when performed, during rest and cardiovascular stress test using treadmill, bicycle exercise and/or pharmacologically induced stress, with interpretation	Prior authorization is managed by EviCore.	Prior authorization is managed b EviCore.
93356	Myocardial strain imaging using speckle tracking-derived assessment of myocardial mechanics (List separately in addition to codes for echocardiography imaging)	Prior authorization is managed by EviCore.	Prior authorization is managed b EviCore.
93451	Right Heart Catheterization Including Measurement(S) Of Oxygen Saturation And Cardiac Output, When Performed	Prior authorization is managed by EviCore.	Prior authorization is managed b EviCore.
93452	Left heart catheterization including intraprocedural injection(s) for left ventriculography, imaging supervision and interpretation, when performed	Prior authorization is required.	
93453	Combined right and left heart catheterization including intraprocedural injection(s) for left ventriculography, imaging supervision and interpretation, when performed	Prior authorization is managed by EviCore.	Prior authorization is managed b EviCore.
93454	Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation	Prior authorization is managed by EviCore.	Prior authorization is managed b EviCore.
93455	Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with catheter placement(s) in bypass graft(s) (internal mammary, free arterial venous grafts) including intraprocedural injection(s) for bypass graft angiography	Prior authorization is managed by EviCore.	Prior authorization is managed b EviCore.
93456	Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with right hear catheterization	Prior authorization is managed by EviCore.	Prior authorization is managed b EviCore.
93457	Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with catheter placement(s) in bypass graft(s) (internal mammary, free arterial, venous grafts) including intraprocedural injection(s) for bypass graft angiography and right heart catheterization	Prior authorization is managed by EviCore.	Prior authorization is managed b EviCore.
93458	Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, inaging supervision and interpretation; with left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed	Prior authorization is managed by EviCore.	Prior authorization is managed b EviCore.
93459	Catheter placement in coronary attery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed, catheter placemet(s) in bypass graft(s) (internal mammary, free arterial, venous grafts) with bypass graft angiography	Prior authorization is managed by EviCore.	Prior authorization is managed b EviCore.

93460	Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation, with right and left heart cathetercation including intraprocedural injection(s) for left ventriculography, when performed	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
93461	Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with right and left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed, catheter placement(s) in bypass graft(s) (internal mammary, free arterial, venous grafts) with bypass graft angiography	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
93462	Left heart catheterization by transseptal puncture through intact septum or by transapical puncture (list separately in addition to code for primary procedure)	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
93580	Percutaneous transcatheter closure of congenital interatrial communication (ie, Fontan fenestration, atrial septal defect) with implant	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1234 Transcatheter Closure Devices for Septal Defects	
93581	Percutaneous transcatheter closure of a congenital ventricular septal defect with implant	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1234 Transcatheter Closure Devices for Septal Defects	
93582	Percutaneous transcatheter closure of patent ductus arteriosus	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1234 Transcatheter Closure Devices for Septal Defects	
93590	Percutaneous transcatheter closure of paravalvular leak; initial occlusion device, mitral valve	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1126 Transcatheter Mitral Valve Repair/Replacement	
93591	Percutaneous transcatheter closure of paravalvular leak; initial occlusion device, aortic valve	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1125 Transcatheter Aortic Valve Replacement	
93592	Percutaneous transcatheter closure of paravalvular leak; each additional occlusion device (List separately in addition to code for primary procedure)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1126 Transcatheter Mitral Valve Repair/Replacement	
93593	Right heart catheterization for congenital heart defect(s) including imaging guidance by the proceduralist to advance the catheter to the target zone; normal native connections	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
93594	Right heart catheterization for congenital heart defect(s) including imaging guidance by the proceduralist to advance the catheter to the target zone; abnormal native connections	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
93595	Left heart catheterization for congenital heart defect(s) including imaging guidance by the proceduralist to advance the catheter to the target zone, normal or abnormal native connections	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
93596	Right and left heart catheterization for congenital heart defect(s) including imaging guidance by the proceduralist to advance the catheter to the target zone(s); normal native connections	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
93597	Right and left heart catheterization for congenital heart defect(s) including imaging guidance by the proceduralist to advance the catheter to the target zone(s); connections abnormal native connections	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
93613	Intracardiac electrophysiologic 3-dimensional mapping (List separately in addition to code for primary procedure)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1187 Cardiac Ablation Procedure	
93650	Intracardiac catheter ablation of atrioventricular node function, atrioventricular conduction for creation of complete heart block, with or without temporary pacemaker placement	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1187 Cardiac Ablation Procedure	
93653	Comprehensive electrophysiologic evaluation with insertion and repositioning of multiple electrode catheters, induction or attempted induction of an arrhythmia with right atrial pacing and recording and catheter ablation of arrhythmogenic focus, including intracardiac electrophysiologic 3-dimensional mapping, right ventricular pacing and recording, left atrial pacing and recording from coronary sinus or left atrium and His bundle recording, when performed; with treatment of supraventricular tachycardia by ablation of fast or slow atrioventricular pathway, accessory atrioventricular conclusion, cavo-tricuspid isthmus or other single atrial focus or source of atrial re-entry	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1187 Cardiac Ablation Procedure	
93654	Comprehensive electrophysiologic evaluation with insertion and repositioning of multiple electrode catheters, induction or attempted induction of an arrhythmia with right atrial pacing and recording and catheter ablation of arrhythmogenic focus, including intracardiac electrophysiologic 3-dimensional mapping, right ventricular pacing and recording, left atrial pacing and recording from coronary sinus or left atrium and His bundle recording, when performed; with treatment of ventricular tachycardia or focus of ventricular ectopy including left ventricular pacing and recording, when performed	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1187 Cardiac Ablation Procedure	
93655	Intracardiac catheter ablation of a discrete mechanism of arrhythmia which is distinct from the primary ablated mechanism, including repeat diagnostic maneuvers, to treat a spontaneous or induced arrhythmia (List separately in addition to code for primary procedure)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1187 Cardiac Ablation Procedure	
93656	Comprehensive electrophysiologic evaluation including transseptal catheterizations, insertion and repositioning of multiple electrode catheters with intracardiac catheter ablation of atrial fibriliation by pulmonary vein isolation, including intracardiac electrophysiologic 3-dimensional mapping, intracardiac echocardiography including imaging supervision and interpretation, induction or attempted induction of an arrhythmia including left or right atrial paing/recording, right ventricular pacing/recording and His bundle recording, when performed	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1187 Cardiac Ablation Procedure	
93657	Additional linear or focal intracardia catheter ablation of the left or right atrium for treatment of atrial fibrillation remaining after completion of pulmonary ven isolation (List separately in addition to code for primary procedure)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1187 Cardiac Ablation Procedure	

Intracardiac echocardiography during therapeutic/diagnostic intervention, including imaging supervision and interpretation (List separately in addition to code for primary procedure)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1187 Cardiac Ablation Procedure
Peripheral arterial disease (PAD) rehabilitation, per session	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1013 Supervised Exercise Therapy for Peripheral Artery Disease
Initial set-up and programming by a physician or other qualified health care professional of wearable cardioverter-defibrillator includes initial programming of system, establishing baseline electronic ECG, transmission of data to data repository, patient instruction in wearing system and patient reporting of problems or events	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1138 Wearable Cardioverter-Defibrillatand
Interrogation of ventricular assist device (VAD), in person, with physician or other qualified health care professional analysis of device parameters (eg, drivelines, alarms, power surges), review of device function (eg, flow and volume status, septum status, recovery), with programming, if performed and report	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1104 Artificial Hearts and Ventricular Assist Devices
Ambulatory blood pressure monitoring, utilizing report-generating software, automated, worn continuously for 24 hours or longer; including recording, scanning analysis, interpretation and report	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1032 Ambulatory Blood Pressure Monitors
Ambulatory blood pressure monitoring, utilizing report-generating software, automated, worn continuously for 24 hours or longer, recording only	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1032 Ambulatory Blood Pressure Monitors
Ambulatory blood pressure monitoring, utilizing report-generating software, automated, worn continuously for 24 hours or longer; scanning analysis with report	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1032 Ambulatory Blood Pressure Monitors
Ambulatory blood pressure monitoring, utilizing report-generating software, automated, worn continuously for 24 hours or longer; review with interpretation and report	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1032 Ambulatory Blood Pressure Monitors
Physician or other qualified health care professional services for outpatient cardiac rehabilitation without continuous ECG monitoring (per session)	Prior authorization is required. Reference policies for additional information.	HHO-DE-RP-1013 Therapy Services
Physician or other qualified health care professional services for outpatient cardiac rehabilitation; with continuous ECG monitoring (per session)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1026 Cardiac Rehab and HHO-DE-RP-1013 Therapy Services
Unlisted cardiovascular service or procedure	Prior authorization is required. Reference policies for additional information. Prior authorization is required for not otherwise classified codes.	HHO-DE-MP-1142 Implantable Pulmonary Artery Pressure Measurement Device
Noninvasive vascular procedure	Prior authorization is required.	
Physician or other qualified health care professional services for outpatient pulmonary	Prior authorization is required. Reference policies for additional information.	HHO-DE-RP-1013 Therapy Services
Physician or other qualified health care professional services for outpatient pulmonary	Prior authorization is required. Reference policies for additional information.	HHO-DE-RP-1013 Therapy Services
Oxygen Optake, Expired Gas Analysis; Rest And Exercise, Direct, Simple	Prior authorization is required. Reference policies for additional information.	HHO-DE-RP-1013 Therapy Services
Circadian respiratory pattern recording (pediatric pneumogram), 12-24 hour continuous recording, infant	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1064 Diagnosis and Treatment of Obstructive Sleep Apnea in Adults and HHO-DE-MP-1065 Diagnosis and Treatment of Obstructive Sleep Apnea in Pediatric Individuals
Pulmonary service	Prior authorization is required.	
Allergy immunology	Prior authorization is required.	
Electroencephalogram (EEG) continuous recording, with video when performed, setup, patient education and takedown when performed, administered in person by EEG technologist, minimum of 8 channels	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1009 Deep Brain Stimulation and HHO-DE-MP-1088 Electroencephalogram (EEG) Technologies
Electroencephalogram (EEG), without video, review of data, technical description by EEG technologist, 2-12 hours; unmonitored	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1009 Deep Brain Stimulation and HHO-DE-MP-1088 Electroencephalogram (EEG) Technologies
Electroencephalogram (EEG), without video, review of data, technical description by EEG technologist, 2-12 hours; with intermittent monitoring and maintenance	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1009 Deep Brain Stimulation and HHO-DE-MP-1088 Electroencephalogram (EEG) Technologies
Electroencephalogram (EEG), without video, review of data, technical description by EEG	Prior authorization is required.	HHO-DE-MP-1009 Deep Brain Stimulation and
		HHO-DE-MP-1088 Electroencephalogram (EEG) Technologies
technologist, each increment of 12-26 hours; unmonitored	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1009 Deep Brain Stimulation and HHO-DE-MP-1088 Electroencephalogram (EEG) Technologies
technologist, each increment of 12-26 hours; with intermittent monitoring and maintenance	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1009 Deep Brain Stimulation and HHO-DE-MP-1088 Electroencephalogram (EEG) Technologies
Electroencephalogram (EEG), without video, review of data, technical description by EEG technologist, each increment of 12-26 hours; with continuous, real-time monitoring and maintenance	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1009 Deep Brain Stimulation and HHO-DE-MP-1088 Electroencephalogram (EEG) Technologies
Electroencephalogram with video (VEEG), review of data, technical description by EEG	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1009 Deep Brain Stimulation and HHO-DE-MP-1088 Electroencephalogram (EEG) Technologies
Electroencephalogram with video (VEEG), review of data, technical description by EEG	Prior authorization is required.	HHO-DE-MP-1009 Deep Brain Stimulation and
technologist, 2-12 hours; with intermittent monitoring and maintenance Electroencephalogram with video (VEEG), review of data, technical description by EEG	Reference policies for additional information. Prior authorization is required.	HHO-DE-MP-1088 Electroencephalogram (EEG) Technologies HHO-DE-MP-1009 Deep Brain Stimulation and
technologist, 2-12 hours; with continuous, real-time monitoring and maintenance	Reference policies for additional information.	HHO-DE-MP-1088 Electroencephalogram (EEG) Technologies HHO-DE-MP-1009 Deep Brain Stimulation and
technologist, each increment of 12-26 hours; unmonitored	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1009 Deep Brain Stimulation and HHO-DE-MP-1088 Electroencephalogram (EEG) Technologies
Electroencephalogram with video (VEEG), review of data, technical description by EEG	Prior authorization is required.	HHO-DE-MP-1009 Deep Brain Stimulation and
technologist, each increment of 12-26 hours; with intermittent monitoring and maintenance Electroencephalogram with video (VEEG), review of data, technical description by EEG	Reference policies for additional information.	HHO-DE-MP-1088 Electroencephalogram (EEG) Technologies
	procedure) Peripheral atterial disease (PAD) rehabilitation, per session Initial set-up and programming by a physician or other qualified health care professional of wearing system and patient reporting of problems or events Interrogation of ventricular assist device (VAD), in person, with physician or other qualified health care professional analysis of device parameters (eg. divelines, alams, power surges), review of device function (eg. flow and volume status, septum status, recovery), with programming, if performed and report Ambulatory blood pressure monitoring, utilizing report-generating software, automated, worm continuously for 24 hours or longer; recording only Ambulatory blood pressure monitoring, utilizing report-generating software, automated, worm continuously for 24 hours or longer; recording only Ambulatory blood pressure monitoring, utilizing report-generating software, automated, worm continuously for 24 hours or longer; relew with interpretation and report Physician or other qualified health care professional services for outpatient cardiac rehabilitation; with continuous ECG monitoring (per session) Physician or other qualified health care professional services for outpatient pulmonary rehabilitation; with out nunuous owimetry monitoring (per session) Physician or other qualified health care professional services for outpatient pulmonary rehabilitation; with out toninuous owimetry monitoring (per session) Physician or other qualified health care professional services for outpatient pulmonary rehabilitation; with outinuous owimetry monitoring (per session) Physician or other qualif	image generation and integration (List speaked y nation) Prior authorization is required. Reference policies for additional information. Prior authorization is required. Reference policies for additional information. Prior authorization is required. Reference policies for additional information. Intel sets quarting by a physication on the generation of the generation

	Electroencephalogram (EEG), continuous recording, physician or other qualified health care		
95717	professional review of recorded events, analysis of spike and seizure detection,	Prior authorization is required.	HHO-DE-MP-1009 Deep Brain Stimulation and
	interpretation and report, 2-12 hours of EEG recording; without video	Reference policies for additional information.	HHO-DE-MP-1088 Electroencephalogram (EEG) Technologies
	Electroencephalogram (EEG), continuous recording, physician or other qualified health care		
95718	professional review of recorded events, analysis of spike and seizure detection,	Prior authorization is required.	HHO-DE-MP-1009 Deep Brain Stimulation and
	interpretation and report, 2-12 hours of EEG recording; with video (VEEG)	Reference policies for additional information.	HHO-DE-MP-1088 Electroencephalogram (EEG) Technologies
	Electroencephalogram (EEG), continuous recording, physician or other qualified health care		
95719	professional review of recorded events, analysis of spike and seizure detection, each	Prior authorization is required.	HHO-DE-MP-1009 Deep Brain Stimulation and
93719	increment of greater than 12 hours, up to 26 hours of EEG recording, interpretation and	Reference policies for additional information.	HHO-DE-MP-1088 Electroencephalogram (EEG) Technologies
	report after each 24-hour period; without video		
	Electroencephalogram (EEG), continuous recording, physician or other qualified health care		
95720	professional review of recorded events, analysis of spike and seizure detection, each	Prior authorization is required.	HHO-DE-MP-1009 Deep Brain Stimulation and
55720	increment of greater than 12 hours, up to 26 hours of EEG recording, interpretation and	Reference policies for additional information.	HHO-DE-MP-1088 Electroencephalogram (EEG) Technologies
	report after each 24-hour period; with video (VEEG)		
	Electroencephalogram (EEG), continuous recording, physician or other qualified health care		
95721	professional review of recorded events, analysis of spike and seizure detection,	Prior authorization is required.	HHO-DE-MP-1009 Deep Brain Stimulation and
	interpretation and summary report, complete study; greater than 36 hours, up to 60 hours	Reference policies for additional information.	HHO-DE-MP-1088 Electroencephalogram (EEG) Technologies
	of EEG recording, without video		
	Electroencephalogram (EEG), continuous recording, physician or other qualified health care		
95722	professional review of recorded events, analysis of spike and seizure detection,	Prior authorization is required.	HHO-DE-MP-1009 Deep Brain Stimulation and
	interpretation and summary report, complete study; greater than 36 hours, up to 60 hours	Reference policies for additional information.	HHO-DE-MP-1088 Electroencephalogram (EEG) Technologies
	of EEG recording, with video (VEEG)		
	Electroencephalogram (EEG), continuous recording, physician or other qualified health care		
95723	professional review of recorded events, analysis of spike and seizure detection,	Prior authorization is required.	HHO-DE-MP-1009 Deep Brain Stimulation and
	interpretation and summary report, complete study; greater than 60 hours, up to 84 hours	Reference policies for additional information.	HHO-DE-MP-1088 Electroencephalogram (EEG) Technologies
	of EEG recording, without video		
	Electroencephalogram (EEG), continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and seizure detection,	Prior authorization is required.	HHO-DE-MP-1009 Deep Brain Stimulation and
95724	professional review of recorded events, analysis of spike and seizure detection, interpretation and summary report, complete study; greater than 60 hours, up to 84 hours	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1009 Deep Brain Stimulation and HHO-DE-MP-1088 Electroencephalogram (EEG) Technologies
	of EEG recording, with video (VEEG)	Reference policies for additional information.	Thro-be-we -1000 electroencephalogram (eed) rechnologies
	of EEG recording, with video (VEEG) Electroencephalogram (EEG), continuous recording, physician or other qualified health care		
	professional review of recorded events, analysis of spike and seizure detection,	Prior authorization is required.	HHO-DE-MP-1009 Deep Brain Stimulation and
95725	interpretation and summary report, complete study; greater than 84 hours of EEG	Reference policies for additional information.	HHO-DE-MP-1009 Deep blan stimulation and HHO-DE-MP-1088 Electroencephalogram (EEG) Technologies
	recording, without video	neiel ence poneres for additional morniation.	
	Electroencephalogram (EEG), continuous recording, physician or other qualified health care		
	professional review of recorded events, analysis of spike and seizure detection,	Prior authorization is required.	HHO-DE-MP-1009 Deep Brain Stimulation and
95726	interpretation and summary report, complete study; greater than 84 hours of EEG	Reference policies for additional information.	HHO-DE-MP-1088 Electroencephalogram (EEG) Technologies
	recording, with video (VEEG)	· · · · · · · · · · · · · · · · · · ·	
05700	Polysomnography; younger than 6 years, sleep staging with 4 or more additional		HHO-DE-MP-1064 Diagnosis and Treatment of Obstructive
95782	parameters of sleep, attended by a technologist	Prior authorization is required. Reference policies for additional information.	Sleep Apnea in Adults and HHO-DE-MP-1065 Diagnosis and
			Treatment of Obstructive Sleep Apnea in Pediatric Individuals
05700	Polysomnography; younger than 6 years, sleep staging with 4 or more additional	Defensively standard Defense in the College in College	HHO-DE-MP-1064 Diagnosis and Treatment of Obstructive
95783	parameters of sleep, with initiation of continuous positive airway pressure therapy or bi-	Prior authorization is required. Reference policies for additional information.	Sleep Apnea in Adults and HHO-DE-MP-1065 Diagnosis and
	level ventilation, attended by a technologist		Treatment of Obstructive Sleep Apnea in Pediatric Individuals
	Multiple sleep latency or maintenance of wakefulness testing, recording, analysis and		HHO-DE-MP-1064 Diagnosis and Treatment of Obstructive
95805	interpretation of physiological measurements of sleep during multiple trials to assess	Prior authorization is required. Reference policies for additional information.	Sleep Apnea in Adults and HHO-DE-MP-1065 Diagnosis and
	sleepiness		Treatment of Obstructive Sleep Apnea in Pediatric Individuals
	Sleep study, unattended, simultaneous recording of, heart rate, oxygen saturation,		HHO-DE-MP-1064 Diagnosis and Treatment of Obstructive
95806	respiratory airflow and respiratory effort (eg, thoracoabdominal movement)	Prior authorization is required. Reference policies for additional information.	Sleep Apnea in Adults and HHO-DE-MP-1065 Diagnosis and
	respiratory annow and respiratory error (eg. dioracoabdornind movement)		Treatment of Obstructive Sleep Apnea in Pediatric Individuals
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	Clean shoke size the papers seconding of contiletion providence of the papers		HHO-DE-MP-1064 Diagnosis and Treatment of Obstructive
95807	Sleep study, simultaneous recording of ventilation, respiratory effort, ECG or heart rate and	Prior authorization is required. Reference policies for additional information.	Sleep Apnea in Adults and HHO-DE-MP-1065 Diagnosis and
	oxygen saturation, attended by a technologist		Treatment of Obstructive Sleep Apnea in Pediatric Individuals
			HHO-DE-MP-1064 Diagnosis and Treatment of Obstructive
95808	Polysomnography; any age, sleep staging with 1-3 additional parameters of sleep,	Prior authorization is required. Reference policies for additional information.	Sleep Apnea in Adults and HHO-DE-MP-1065 Diagnosis and
	attended by a technologist	• • • • • • • • • • • • • • • • • • • •	Treatment of Obstructive Sleep Apnea in Pediatric Individuals
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			HHO-DE-MP-1064 Diagnosis and Treatment of Obstructive
95810	Polysomnography; age 6 years or older, sleep staging with 4 or more additional	Prior authorization is required. Reference policies for additional information.	Sleep Apnea in Adults and HHO-DE-MP-1065 Diagnosis and
55610	parameters of sleep, attended by a technologist		Treatment of Obstructive Sleep Apnea in Pediatric Individuals
	Polysomnography; age 6 years or older, sleep staging with 4 or more additional		HHO-DE-MP-1064 Diagnosis and Treatment of Obstructive
95811	parameters of sleep, with initiation of continuous positive airway pressure therapy or	Prior authorization is required. Reference policies for additional information.	Sleep Apnea in Adults and HHO-DE-MP-1065 Diagnosis and
55011	bilevel ventilation, attended by a technologist	The automation arequired, here ence poners for additional mornation.	Treatment of Obstructive Sleep Apnea in Pediatric Individuals
	bicver versitation, accrited by a technologist		

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95812	Electroencephalogram (EEG) extended monitoring; 41-60 minutes	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1009 Deep Brain Stimulation and HHO-DE-MP-1088 Electroencephalogram (EEG) Technologies	
05040		Prior authorization is required.	HHO-DE-MP-1009 Deep Brain Stimulation and	
95813	Electroencephalogram (EEG) extended monitoring; 61-119 minutes	Reference policies for additional information.	HHO-DE-MP-1088 Electroencephalogram (EEG) Technologies	
05010	Flater and the second	Prior authorization is required.	HHO-DE-MP-1009 Deep Brain Stimulation and	
95819	Electroencephalogram (EEG); including recording awake and asleep	Reference policies for additional information.	HHO-DE-MP-1088 Electroencephalogram (EEG) Technologies	
95824	Electroencephalogram (EEG); cerebral death evaluation only	Prior authorization is required.	HHO-DE-MP-1009 Deep Brain Stimulation and	
55824	Electroencephalogram (EEG), celebrar death evaluation only	Reference policies for additional information.	HHO-DE-MP-1088 Electroencephalogram (EEG) Technologies	
95836	Electrocorticogram from an implanted brain neurostimulator pulse generator/transmitter, including recording, with interpretation and written report, up to 30 days	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1009 Deep Brain Stimulation	
95867	Needle electromyography; cranial nerve supplied muscle(s), unilateral	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1136 Temporomandibular Joint Dysfunction	
95868	Needle electromyography; cranial nerve supplied muscles, bilateral	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1136 Temporomandibular Joint Dysfunction	
95925	Short-latency somatosensory evoked potential study, stimulation of any/all peripheral nerves or skin sites, recording from the central nervous system; in upper limbs	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1136 Temporomandibular Joint Dysfunction	
95937	Neuromuscular junction testing (repetitive stimulation, paired stimuli), each nerve, any 1 method	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1136 Temporomandibular Joint Dysfunction	
95961	Functional cortical and subcortical mapping by stimulation and/or recording of electrodes on brain surface, or of depth electrodes, to provoke seizures or identify vital brain structures; initial hour of attendance by a physician or other qualified health care professional	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1009 Deep Brain Stimulation and HHO-DE-MP-1088 Electroencephalogram (EEG) Technologies	
95962	Functional cortical and subcortical mapping by stimulation and/or recording of electrodes on brain surface, or of depth electrodes, to provoke seizures or identify vital brain structures; each additional hour of attendance by a physician or other qualified health care professional (List separately in addition to code for primary procedure)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1009 Deep Brain Stimulation and HHO-DE-MP-1088 Electroencephalogram (EEG) Technologies	
95970	Electronic analysis of implanted neurostimulator pulse generator/transmitter (eg, contact group(s), interleaving, amplitude, pulse width, frequency [Hz], on/off cycling, burst, magnet mode, dose lockout, patient selectable parameters, responsive neurostimulation, detection algorithms, dosed loop parameters and passive parameters) by physician or other qualified health care professional; with brain, cranial nerve, spinal cord, peripheral nerve, or sacral nerve, neurostimulator pulse generator/transmitter, without programming	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1009 Deep Brain Stimulation and HHO-DE-MP- 1131 Responsive Neurostimulation for the Treatment of Refractory Partial Epilepsy	
95976	Electronic analysis of implanted neurostimulator pulse generator/transmitter (eg, contact group[s], interfeaving, amplitude, pulse width, frequency [Hz], on/off cycling, burst, magnet mode, dose lockout, patient selectable parameters, responsive neurostimulation, detection algorithms, closed loop parameters and passive parameters) by physician or other qualified health care professional; with simple cranial nerve neurostimulator pulse generator/transmitter programming by physician or other qualified health care professional	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1009 Deep Brain Stimulation and HHO-DE-MP- 1131 Responsive Neurostimulation for the Treatment of Refractory Partial Epilepsy	
95977	Electronic analysis of implanted neurostimulator pulse generator/transmitter (eg, contact group[s], interleaving, amplitude, pulse width, frequency [Hz], on/off cycling, burst, magnet mode, dose lockout, patient selectable parameters, responsive neurostimulation, detection algorithms, dosed loop parameters and passive parameters) by physician or other qualified health care professional; with complex cranial nerve neurostimulator pulse generator/transmitter programming by physician or other qualified health care professional	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1009 Deep Brain Stimulation and HHO-DE-MP- 1131 Responsive Neurostimulation for the Treatment of Refractory Partial Epilepsy	
95980	Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient measurements) gastric neurostimulator pulse generator/transmitter, intraoperative, with programming	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1235 Gastric Electrical Stimulation and Gastric Pacing	
95981	Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient measurements) gastric neurostimulator pulse generator/transmitter; subsequent, without reprogramming	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1235 Gastric Electrical Stimulation and Gastric Pacing	
95982	Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient measurements) gastric neurostimulator pulse generator/transmitter, subsequent, with reprogramming	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1235 Gastric Electrical Stimulation and Gastric Pacing	
95983	Electronic analysis of implanted neurostimulator pulse generator/transmitter (eg, contact group[s], interfeaving, amplitude, pulse width, frequency [Hz], on/off cycling, burst, magnet mode, dose lockout, patient selectable parameters, responsive neurostimulation, detection algorithms, closed loop parameters and passive parameters) by physician or other qualified health care professional; with brain neurostimulator pulse generator/transmitter programming, first 15 minutes face-to-face time with physician or other qualified health care professional	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1009 Deep Brain Stimulation and HHO-DE-MP- 1131 Responsive Neurostimulation for the Treatment of Refractory Partial Epilepsy	
95984	Electronic analysis of implanted neurostimulator pulse generator/transmitter (eg, contact group[s], interleaving, amplitude, pulse width, frequency [Hz], on/off cycling, burst, magnet mode, dose lockout, patient selectable parameters, responsive neurostimulation, detection algorithms, closed loop parameters and passive parameters) by physician or other qualified health care professional; with brain neurostimulator pulse generator/transmitter programming, each additional 15 minutes face-to-face time with physician or other qualified health care professional (List separately in addition to code for primary procedure)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1009 Deep Brain Stimulation and HHO-DE-MP- 1131 Responsive Neurostimulation for the Treatment of Refractory Partial Epilepsy	

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

96573	Photodynamic therapy by external application of light to destroy premalignant lesions of the skin and adjacent mucosa with application and illumination/activation of photosensitizing drug(s) provided by a physician or other qualified health care professional, per day	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1034 Treatment of Malignant Skin Lesions
96574	Debridement of premalignant hyperkeratotic lesion(s) (ie, targeted curettage, abrasion) followed with photodynamic therapy by external application of light to destroy premalignant lesions of the skin and adjacent mucosa with application and illumination/activation of photosensitizing drug(s) provided by a physician or other qualified health care professional, per day	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1034 Treatment of Malignant Skin Lesions
96999	Unlisted special dermatological service or procedure	Prior authorization is required.	
97032	Application of a modality to 1 or more areas; electrical stimulation (manual), each 15 minutes	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1117 Urinary Incontinence Therapy
97033	Application of a modality to 1 or more areas; iontophoresis, each 15 minutes	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1136 Temporomandibular Joint Dysfunction and HHO-DE-MP-1137 Hyperhidrosis
97039	Unlisted physical medicine	Prior authorization is required.	
97110	Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility.	Prior authorization is required. Reference policies for additional information.	HHO-DE-RP-1013 Therapy Services
97113	Therapeutic Procedure, 1 Or More Areas, Each 15 Minutes; Aquatic Therapy With Therapeutic Exercises	Prior authorization is required. Reference policies for additional information.	HHO-DE-RP-1013 Therapy Services
97124	Therapeutic procedure, 1 or more areas, each 15 minutes; massage, including effleurage, petrissage and/or tapotement (stroking, compression, percussion)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1136 Temporomandibular Joint Dysfunction
97129	Therapeutic interventions that focus on cognitive function (eg, attention, memory, reasoning, executive function, problem solving and/or pragmatic functioning) and compensatory strategies to manage the performance of an activity (eg, managing time or schedules, initiating, organizing and sequencing tasks), direct (one-on-one) patient contact; initial 15 minutes	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1044 Cognitive Rehabilitation
97130	Therapeutic interventions that focus on cognitive function (eg, attention, memory, reasoning, executive function, problem solving and/or pragmatic functioning) and compensatory strategies to manage the performance of an activity (eg, managing time or schedules, initiating, organizing and sequencing tasks), direct (one-on-one) patient contact; each additional 15 minutes (List separately in addition to code for primary procedure)	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1044 Cognitive Rehabilitation
97139	Unlisted physical medicine	Prior authorization is required.	
97140	Manual therapy techniques (eg, mobilization/ manipulation, manual lymphatic drainage, manual traction), 1 or more regions, each 15 minutes	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1136 Temporomandibular Joint Dysfunction
97151	Behavior identification assessment, administered by a physician or other qualified health care professional, each 15 minutes of the physician's or other qualified health care professional's time face-to-face with patient and/or guardian(s)/caregiver(s) administering assessments and discussing findings and recommendations and non-face-to-face analyzing past data, scoring/interpreting the assessment and preparing the report/treatment plan	Prior authorization is required.	
97530	Therapeutic activities, direct (one-on-one) patient contact (use of dynamic activities to improve functional performance), each 15 minutes	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1117 Urinary Incontinence Therapy and HHO-DE- RP-1013 Therapy Services
97605	Negative pressure wound therapy (eg, vacuum assisted drainage collection), utilizing durable medical equipment (DME), including topical application(s), wound assessment and instruction(s) for ongoing care, per session; total wound(s) surface area less than or equal to 50 square centimeters	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1039 Negative Pressure Wound Therapy
97606	Negative pressure wound therapy (eg, vacuum assisted drainage collection), utilizing durable medical equipment (DME), including topical application(s), wound assessment and instruction(s) for ongoing care, per session; total wound(s) surface area greater than 50 square centimeters	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1039 Negative Pressure Wound Therapy
97750	Physical Performance Test Or Measurement (eg, Musculoskelteal, Functional Capacity), With Written Report, Each 15 Minutes	Prior authorization is required. Reference policies for additional information.	HHO-DE-RP-1013 Therapy Services
97760	Orthotic (s) Management And Training (including Assessment And Fitting When Not Otherwise Reported), Upper Extremity(ies), Lower Extremity(ies) And/or Trunk, Initial Orthotic(s) Encounter, Each 15 Minutes	Prior authorization is required. Reference policies for additional information.	HHO-DE-RP-1013 Therapy Services
97761	Prosthetic(s) Training, Upper And/or Lower Extremity (ies), Initial Prosthetic (s) Encounter, Each 15 Minutes	Prior authorization is required. Reference policies for additional information.	HHO-DE-RP-1013 Therapy Services
97763	Orthotic(s)/prosthetic(s) Management And/or Training, Upper Extremity(ies), Lower Extremity(ies) and/or Trunk, Subsequent Orthotic(s) Encounter, Each 15 Minutes	Prior authorization is required. Reference policies for additional information.	HHO-DE-RP-1013 Therapy Services
97799	Unlisted physical medicine/rehabilitation service or procedure	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1136 Temporomandibular Joint Dysfunction
98940	Chiropractic manipulative treatment (CMT); spinal, 1-2 regions	Prior authorization is required for members under age 13. Prior authorization is required for members age 13 and older after the first 26 manipulations. Reference policies for additional information.	HHO-DE-RP-1120 Chiropractic Benefits and Services
98941	Chiropractic manipulative treatment (CMT); spinal, 3-4 regions	Prior authorization is required for members under age 13. Prior authorization is required for members age 13 and older after the first 26 manipulations. Reference policies for additional information.	HHO-DE-RP-1120 Chiropractic Benefits and Services
98942	Chiropractic manipulative treatment (CMT); spinal, 5 regions	Prior authorization is required for members under age 13. Prior authorization is required for members age 13 and older after the first 26 manipulations. Reference policies for additional information.	HHO-DE-RP-1120 Chiropractic Benefits and Services

98943	Chiropractic manipulative treatment (CMT); extraspinal, 1 or more regions	Prior authorization is required for members under age 13. Prior authorization is required for members age 13 and older after the first 26 manipulations. Reference policies for additional information.	HHO-DE-RP-1120 Chiropractic Benefits and Services	
99091	Collection And Interpretation Of Physiologic Data (eg, Ecg, Blood Pressure, Glucose Monitoring), Digitally Stored And/or Transmitted By The Patient And/or Caregiver To The Physician Or Other Qualified Healthcare Professional, Requiring A Minimum Of 30 Minutes Of Time	Prior authorization is required. Reference policies for additional information.	HHO-DE-RP-1013 Therapy Services	
99183	Physician or other qualified health care professional attendance and supervision of hyperbaric oxygen therapy, per session	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1029 Hyperbaraic Oxygen Therapy	
99184	Initiation of selective head or total body hypothermia in the critically ill neonate, includes appropriate patient selection by review of clinical, imaging and laboratory data, confirmation of esophageal temperature probe location, evaluation of amplitude EEG, supervision of controlled hypothermia and assessment of patient tolerance of cooling	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1009 Deep Brain Stimulation and HHO-DE-MP-1088 Electroencephalogram (EEG) Technologies	
99199	Unlisted special service, procedure, or report	Prior authorization is required.		
55155	Office or other outpatient visit for the evaluation and management of a new patient, which	The automation srequired.		
99202	requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 15-29 minutes of total time is spent on the date of the encounter.	Prior authorization is required for members under age 13 when performed by a Chiropractor. Reference policies for additional information.	HHO-DE-RP-1120 Chiropractic Benefits and Services	
99203	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of the encounter for code selection, 30- 44 minutes of total time is spent on the date of the encounter.	Prior authorization is required for members under age 13 when performed by a Chiropractor. Reference policies for additional information.	HHO-DE-RP-1120 Chiropractic Benefits and Services	
99204	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 45-59 minutes of total time is spent on the date of the encounter.	Prior authorization is required for members under age 13 when performed by a Chiropractor. Reference policies for additional information.	HHO-DE-RP-1120 Chiropractic Benefits and Services	
99205	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 60- 74 minutes of total time is spent on the date of the encounter	Prior authorization is required for members under age 13 when performed by a Chiropractor. Reference policies for additional information.	HHO-DE-RP-1120 Chiropractic Benefits and Services	
99211	Office or other outpatient visit for the evaluation and management of an established patient that may not require the presence of a physician or other qualified health care professional	Prior authorization is required for members under age 13 when performed by a Chiropractor. Reference policies for additional information.	HHO-DE-RP-1120 Chiropractic Benefits and Services	
99212	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 10-19 minutes of total time is spent on the date of the encounter.	Prior authorization is required for members under age 13 when performed by a Chiropractor. Reference policies for additional information.	HHO-DE-RP-1120 Chiropractic Benefits and Services	
99213	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of the encounter for code selection, 20-29 minutes of total time is spent on the date of the encounter.	Prior authorization is required for members under age 13 when performed by a Chiropractor. Reference policies for additional information.	HHO-DE-RP-1120 Chiropractic Benefits and Services	
99214	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 30-39 minutes of total time is spent on the date of the encounter.	Prior authorization is required for members under age 13 when performed by a Chiropractor. Reference policies for additional information.	HHO-DE-RP-1120 Chiropractic Benefits and Services	
99215	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 40-54 minutes of total time is spent on the date of the encounter.	Prior authorization is required for members under age 13 when performed by a Chiropractor. Reference policies for additional information.	HHO-DE-RP-1120 Chiropractic Benefits and Services	
99223	Initial hospital care, per day, for the evaluation and management of a patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission are of high severity. Typically, 20 minutes are spent at the bedside and on the patient's hospital floor or unit.	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1143 Physician Certification and Recertification of Home Health Services	
99224	Subsequent observation care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: Problem focused interval history; Problem focused examination; Medical decision making that is straightforward or of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is stable, recovering, or improving. Typically, 15 minutes are spent at the bedside and on the patient's hospital floor or unit.	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1143 Physician Certification and Recertification of Home Health Services	

99239	Hospital discharge day management; more than 30 minutes	Prior authorization is required. Reference policies for additional information.		
99238	Hospital discharge day management; 30 minutes or less	Prior authorization is required. Reference policies for additional information.	of Home Health Services HHO-DE-MP-1143 Physician Certification and Recertification	
99238		Prior authorization is required. Reference policies for additional information	HHO-DE-MP-1143 Physician Certification and Recertification	
p	presenting problem(s) requiring admission are of high severity. Typically, 55 minutes are spent at the bedside and on the patient's hospital floor or unit.			
	with the nature of the problem(s) and the patient's and/or family's needs. Usually the			
F	physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's peeds. Usually, the		of Home Health Services	
	decision making of high complexity. Counseling and/or coordination of care with other	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1143 Physician Certification and Recertification	
	components: A comprehensive history; A comprehensive examination; and Medical			
	including admission and discharge on the same date, which requires these 3 key			
	Observation or inpatient hospital care, for the evaluation and management of a patient			
	50 minutes are spent at the bedside and on the patient's hospital floor or unit.			
	sually the presenting problem(s) requiring admission are of moderate severity. Typically,			
	consistent with the nature of the problem(s) and the patient's and/or family's needs.			
99235	other physicians, other qualified health care professionals, or agencies are provided	Prior authorization is required. Reference policies for additional information.	of Home Health Services	
	decision making of moderate complexity. Counseling and/or coordination of care with		HHO-DE-MP-1143 Physician Certification and Recertification	
	including admission and discharge on the same date, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical			
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,	hospital floor or unit. Observation or inpatient hospital care, for the evaluation and management of a patient		<u> </u>	
	are of low severity. Typically, 40 minutes are spent at the bedside and on the patient's			
	e patient's and/or family's needs. Usually the presenting problem(s) requiring admission			
	professionals, or agencies are provided consistent with the nature of the problem(s) and			
	Counseling and/or coordination of care with other physicians, other qualified health care	Prior authorization is required. Reference policies for additional information.	of Home Health Services	
	examination; and Medical decision making that is straightforward or of low complexity.		HHO-DE-MP-1143 Physician Certification and Recertification	
	components: A detailed or comprehensive history; A detailed or comprehensive			
	including admission and discharge on the same date, which requires these 3 key			
(Observation or inpatient hospital care, for the evaluation and management of a patient			
	patient's hospital floor or unit.			
	significant new problem. Typically, 35 minutes are spent at the bedside and on the			
	needs. Usually, the patient is unstable or has developed a significant complication or a			
	provided consistent with the nature of the problem(s) and the patient's and/or family's	Prior authorization is required. Reference policies for additional information.	of Home Health Services	
	of care with other physicians, other qualified health care professionals, or agencies are		HHO-DE-MP-1143 Physician Certification and Recertification	
	camination; Medical decision making of high complexity. Counseling and/or coordination			
	requires at least 2 of these 3 key components: A detailed interval history; A detailed			
Su	ubsequent hospital care, per day, for the evaluation and management of a patient, which		<u> </u>	
	spent at the bedside and on the patient's hospital floor or unit.			
	adequately to therapy or has developed a minor complication. Typically, 25 minutes are			
	problem(s) and the patient's and/or family's needs. Usually, the patient is responding			
99232	health care professionals, or agencies are provided consistent with the nature of the	Prior authorization is required. Reference policies for additional information.	of Home Health Services	
	complexity. Counseling and/or coordination of care with other physicians, other qualified		HHO-DE-MP-1143 Physician Certification and Recertification	
	story; An expanded problem focused examination; Medical decision making of moderate			
	requires at least 2 of these 3 key components: An expanded problem focused interval			
Su	ubsequent hospital care, per day, for the evaluation and management of a patient, which		1	
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	recovering or improving. Typically, 15 minutes are spent at the bedside and on the			
	problem(s) and the patient's and/or family's needs. Usually, the patient is stable,		of the mean of the second	
	health care professionals, or agencies are provided consistent with the nature of the	Prior authorization is required. Reference policies for additional information.	of Home Health Services	
	complexity. Counseling and/or coordination of care with other physicians, other qualified		HHO-DE-MP-1143 Physician Certification and Recertification	
	requires at least 2 of these 3 key components: A problem focused interval history; A problem focused examination; Medical decision making that is straightforward or of low			
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	patient's hospital floor or unit.			
	significant new problem. Typically, 35 minutes are spent at the bedside and on the			
	needs. Usually, the patient is unstable or has developed a significant complication or a			
	provided consistent with the nature of the problem(s) and the patient's and/or family's		of Home Health Services	
	of care with other physicians, other qualified health care professionals, or agencies are	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1143 Physician Certification and Recertification	
	xamination; Medical decision making of high complexity. Counseling and/or coordination			
	hich requires at least 2 of these 3 key components: A detailed interval history; A detailed			
	Subsequent observation care, per day, for the evaluation and management of a patient,			
	spent at the bedside and on the patient's hospital floor or unit.			
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	he problem(s) and the patient's and/or family's needs. Usually, the patient is responding			
99225 q	ualified health care professionals, or agencies are provided consistent with the nature of	Prior authorization is required. Reference policies for additional information.	of Home Health Services	
	noderate complexity. Counseling and/or coordination of care with other physicians, other	Dring authorization is required. Deference	HHO-DE-MP-1143 Physician Certification and Recertification	
	nterval history; An expanded problem focused examination; Medical decision making of			
	which requires at least 2 of these 3 key components: An expanded problem focused			

99304	Initial nursing facility care, per day, for the evaluation and management of a patient, which requires these 3 key components: A detailed or comprehensive history; A detailed or comprehensive examination; and Medical decision making that is straightforward or of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission are of low severity. Typically, 25 minutes are spent at the beside and on the patient's facility floor or unit.	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1143 Physician Certification and Recertification of Home Health Services	
99305	Initial nursing facility care, per day, for the evaluation and management of a patient, which requires these 3 key components: A comprehensive history: A comprehensive examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission are of moderate severity. Typically, 35 minutes are spent at the bedside and on the patient's facility floor or unit.	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1143 Physician Certification and Recertification of Home Health Services	
99306	Initial nursing facility care, per day, for the evaluation and management of a patient, which requires these 3 key components: A comprehensive history: A comprehensive examination; and Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) produments and are verity. Typically, 45 minutes are spent at the bedside and on the patient's facility floor or unit.	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1143 Physician Certification and Recertification of Home Health Services	
99307	Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A problem focused interval history: A problem focused examination; Straightforward medical decision making. Courseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is stable, recovering, or improving. Typically, 10 minutes are spent at the bedside and on the patient's facility floor or unit.	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1143 Physician Certification and Recertification of Home Health Services	
99308	Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: An expanded problem focused interval history; An expanded problem focused examination; Medical decision making of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(5) and the patient's and/or family's needs. Usually, the patient is responding inadequately to therapy or has developed a minor complication. Typically, 15 minute are spent at the bedside and on the patient's facility floor or unit.	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1143 Physician Certification and Recertification of Home Health Services	
99309	Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A detailed interval history; A detailed examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient has developed a significant complication or a significant new problem. Typically, 25 minutes are spent at the bedside and on the patient's facility floor or unit.	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1143 Physician Certification and Recertification of Home Health Services	
99310	Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A comprehensive interval history; A comprehensive examination; Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. The patient may be unstable or may have developed a significant new problem requiring immediate physician attention. Typically, 35 minutes are spent at the bedside and on the patient's facility floor or unit.	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1143 Physician Certification and Recertification of Home Health Services	
99318	Evaluation and management of a patient involving an annual nursing facility assessment, which requires these 3 key components: A detailed interval history; A comprehensive examination; and Medical decision making that is of low to moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(5) and the patient's and/or family's needs. Usually, the patient is stable, recovering, or improving. Typically, 30 minutes are spent at the bedside and on the patient's facility floor or unit.	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1143 Physician Certification and Recertification of Home Health Services	
99341	Home visit for the evaluation and management of a new patient, which requires these 3 key components: A problem focused history: A problem focused examination; and Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low seventy. Typically, 20 minutes are spent face-to-face with the patient and/or family.	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1143 Physician Certification and Recertification of Home Health Services	

99342	Home visit for the evaluation and management of a new patient, which requires these 3 key components: An expanded problem focused history; An expanded problem focused examination; and Medical decision making of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity. Typically, 30 minutes are spent face-to-face with the patient and/or family.	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1143 Physician Certification and Recertification of Home Health Services	
99343	Home visit for the evaluation and management of a new patient, which requires these 3 key components: A detailed history; A detailed examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 45 minutes are spent face-to-face with the patient and/or family.	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1143 Physician Certification and Recertification of Home Health Services	
99344	Home visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of high severity. Typically, 60 minutes are spent face-to-face with the patient and/or family.	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1143 Physician Certification and Recertification of Home Health Services	
99345	Home visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is unstable or has developed a significant new problem requiring immediate physician attention. Typically, 75 minutes are spent face-to-face with the patient and/or family.	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1143 Physician Certification and Recertification of Home Health Services	
99347	Home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A problem focused interval history; A problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Typically, 15 minutes are spent face-to-face with the patient and/or family.	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1143 Physician Certification and Recertification of Home Health Services	
99348	Home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: An expanded problem focused interval history; An expanded problem focused examination; Medical decision making of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Typically, 25 minutes are spent face-to-face with the patient and/or family.	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1143 Physician Certification and Recertification of Home Health Services	
99349	Home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A detailed interval history; A detailed examination; Medical decision making of moderate complexity. Courseling and/or complication of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are moderate to high severity. Typically, 40 minutes are spent face-to-face with the patient and/or family.	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1143 Physician Certification and Recertification of Home Health Services	
99350	Home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A comprehensive interval history; A comprehensive examination; Medical decision making of moderate to high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. The patient may be unstable or may have developed a significant new problem requiring immediate physician attention. Typically, 60 minutes are spent face-to-face with the patient and/or family.	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1143 Physician Certification and Recertification of Home Health Services	
99499	Evaluation and management service	Prior authorization is required.		
99600	Unlisted home visit	Prior authorization is required.		
J0219	Injection, avalglucosidase alfa-ngpt, 4 mg	Prior authorization is required.		
J0491	Unclassified biologics Injection, anifrolumab-fnia, 1 mg	Prior authorization is required.		
0001U	Red blood cell antigen typing, DNA, human erythrocyte antigen gene analysis of 35	Prior authorization is required.		
0004M	antigens from 11 blood groups, utilizing whole blood, common RBC alleles reported Scoliosis, DNA analysis of 53 single nucleotide polymorphisms (SNPs), using saliva, prognostic algorithm reported as a risk score	Prior authorization is required.		
0005U	Oncology (prostate) gene expression profile by real-time RT-PCR of 3 genes (ERG, PCA3 and SPDEF), urine, algorithm reported as risk score	Prior authorization is required.		
0006M	Oncology (hepatic), mRNA expression levels of 161 genes, utilizing fresh hepatocellular carcinoma tumor tissue, with alpha-fetoprotein level, algorithm reported as a risk classifier	Prior authorization is required.		
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OD16U transcripts, quantitative PCR amplification, bod or bone marrow, report of fusion not detected or detected with quantitation. Prior authorization is required. 0017U 14 and sequence analysis, block or bone marrow, report of IAX2 mutation not detected or detected Prior authorization is required. Image: Comparison of the comparison
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0017U 14 and sequence analysis, biod or borne marrow, report of IAX2 mutation not detected or detected Prior authorization is required. 0018U Oncology (thyroid), microRNA profile by RT-PCR of 10 microRNA sequences, utilizing fine needle aspirate, algorithm reported as a positive or negative result for moderate to high needle aspirate, algorithm reported as a positive or negative result for moderate to high needle aspirate, algorithm reported as a positive or negative result for moderate to high needle aspirate, algorithm reported as a positive or negative result for moderate to high needle aspirate, algorithm reported as positive or negative result for moderate to high needle aspirate for threapeutic agents Prior authorization is required. 0019U particle genomic sequence narking and aspectific benerated target genomic sequence narking and associable therapeutic agents Prior authorization is required. 0022U analysis, 23 genes, interngation for sequence variants and rearragements, reported as presence or variants and associable therapeutic agents Prior authorization is required. 0023U Oncology (favoid), Nut and mRNA of 112 genes, neet, generation sequencing, line needle apprise of thy origin double, algorithm, analysis reported as a totection or non-detection of P13 mutation and indication for or algorith certe analysis top mutation and indication for analysis tepreted as a totegorital result of high probability of malignancy'' Prior authorization is required. 0025U asplotise constrained and up response', largeted sequence analysis cons 21-5. Prior authorization is required. 002
Image: Control of the state state of the state state of the state state of the state state state of the state state of the state state of the state state of the state state state of the state state of the state state state of the state state of the state state of the state state of the state state state of the state state state of the state state state state of the state state state of the state state state state state state state state of the state st
Oncolagy (Myroid), microRNA profiling by RT-FCR 10 microRNA sequences, utilizing fine neede aspirate, algorithm reported as positive or regative result for moderate to high nsk of malignancy Prior authorization is required. 0018U parfile-methodic susce profiles asports or regative result for moderate to high nsk of malignancy Prior authorization is required. 0019U parfile-methodic susce profiles tasse, profiles as potential targets for threapeutic agents Prior authorization is required. 0022U Targeted genomic susce, profiles as potential presence or adherror (heropylicity) and as associate therapylicity to consider Prior authorization is required. 0023U Oncology (Myroid), MAX and mRNA of 112 genes, interrogation for sequence analysis as a categorical result of the farapylicity to consider Prior authorization is required. 0025U Docology (furyiod), DNA and mNA of 112 genes, next-generation sequencing, fine needel aspirated thyroid nodue, algorithm categories a categorical result. (Positive, high probability of malignancy) " Negative, low probability of malignancy" Prior authorization is required. 0025U Junc tabolism (dverse during regionse), targeted sequence analysis, tiggeted sequence analysis exorts as a categorical result. Prior authorization is required. 0025U Junc tabolism (dverse during regionse), targeted sequence analysis exorts as a categorical result. Prior authorization is required. 0025U Junc tabolism (dverse during regionse), t
0018U needle sprate, algorithm corted as a positive or negative result for moderate to high risk of malignancy Prior authorization is required. 0019U Oncology, RNA, gene expression by whole transcriptome sequencing, formalin-fixed parafilm-embedded tissue or friesh frozen tissue, predictive algorithm reported as a potential targets of threnpeutic agents Prior authorization is required. 0022U Targeted genonic sequence analysis panel, non-small cell lung neoplasis, DNA and RNA Prior authorization is required. 0022U Targeted genonic sequence analysis panel, non-small cell lung neoplasis, DNA and RNA Prior authorization is required. 0023U Docology (Jouce myelogenous leukemis), DNA, genotyping of internal tandem duplication, mutation and indication for or against the use of midostaurin mutation and indication for or against the use of midostaurin mutation and indication for or against the use of midostaurin mutation and indication for or against the use of midostaurin mutation and indication for or against the use of midostaurin mutation and indication for or against the use of midostaurin mutation analysis exported as a categorical result ("Positive high probability of malignancy" or "Negative, low probability of malignancy" high probability of malignancy" or "Negative, low probability of malignancy" (ie, CYF1AZ, CYP2C19, CYF2DS, CYF2
Instrume risk of malgnancy Instrume 0019U parfine-metedder suscerifyeth rearres/ptendixe sequencing, formalin-fixed particular sequencing, formalin-fixed particular sequencing, formalin-fixed particular sequence analysis, 23 genes, interrogation for sequence variants and spottation and sequence variants and associated therapylicy is to consider Prior authorization is required. 0022U Targeted genomics sequence analysis part, non-small cellung neoplexis, DNA and RNA analysis, 23 genes, interrogation for sequence variants and associated therapylicy is to consider Prior authorization is required. 0022U Targeted genomics between dv variants and associated therapylicy is to consider Prior authorization is required. 0023U p.D835, p.1836, using monnuclear cells, reported as detection or non-detection of FI13 mutation and indication for or against the use of midostautin module associated therapylicy is to consider Prior authorization is required. 0026U aspirate of thyroid nodule, algorithmic analysis reported as a detection or non-detection of FI13 mutation and indication for or against the use of midostautin mutation is required. Prior authorization is required. 0026U aspirate of thyroid nodule, algorithmic analysis reported as a categorical result (Postive, analysis exons 12-15 mutation and ingrancy") Prior authorization is required. 0027U IAX2 (lanus kinase 2) (eg. myeloproliferative disorder) gene analysis, targeted sequence analysis (exors 12-15 mutation is required. Prior authorization is required. 0029U (e, (YF1A2, (YP2C9, (YF2C9, (YF2C6, (YF2A4, (YF3A5, (YFA7
Oncology, RNA, gene expression by whole transcriptome sequencing, formalin-fixed Prior authorization is required. 0019U parafin-embedded tissue or fresh frozen tissue, predictive agontim reported as potential Prior authorization is required. 0022U analysis, 23 gene, interrogation for sequence analysis panel, non-small cell lung neoplasia, DNA and RNA analysis, 23 gene, interrogation for sequence analysis and exarangements, reported as a subject of prior authorization is required. Prior authorization is required. 0023U Dosology (acute myelogenous leukemia), DNA, genotyping of internal tandem duplication, p. D835, p.186, using mononuclear cells, reported as a detection or non-detection of FLT3 Prior authorization is required. 0023U Docology (tructing), DNA and RNA reported as a detection on no-detection of FLT3 Prior authorization is required. 0026U aspirate of thyroid nodule, algorithmic analysis reported as a categorical result ("Positive, high probability of malignancy" or "Negative, low probability of malignancy") Prior authorization is required. 0027U JAK2 (Janus Kinase 2) (eg. myeloproliferative disorder) gene analysis, targeted sequence analysis (tructore analysis topset, largeted sequence analysis (in (CYP2G), CYP2G), CYP2G), CYP2G, CYP2A, CYP45, SCO1B1, VKORC1 and ris12777823) Prior authorization is required. 0030U Drug metabolism (warfarin drug response), targeted sequence analysis (if, CYP2G), CYP2A, VKORC1, n12777823) Prior authorization is required. 0030U CYP1A2 (CYro
0019U parafin-embedded tissue or fresh frozen tissue, predictive algorithm reported as potential Prior authorization is required. edited 0022U Targeted genomic sequence analysis panel, non-small cell lung neoplasis, DNA and RNA analysis, 23 genes, interngation for sequence variants and rearrangements, reported as presence or variants and associated therapy(les) to consider Prior authorization is required. edited 0022U Oncology (auto: myelogenosi leukenia), DNA, genotyping of internal tandem duplication, p. D835, D1836, using monorucker cells, reported as detection or no-detection of F173 mutation and indication for againets the use of midosta urin nucleon and indication for againets of the support of sequence analysis expected as a categorical result (Positive, high probability of malignancy") Prior authorization is required. enditional sequired. 0027U JAK2 (Janus kinase 2) (eg., myeloproliferative disorder) gene analysis, targeted sequence analysis (tergeted seque
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Market State 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 therapylice) to consider presence or absence of variants and associated therapylice) to consider Prior authorization is required. 0023U Oncology (acute myelogenous leukema), DNA, genotyping of internal tandet duplication, p. D835, p. 1836, using mononuclear cells, reported as detection or non-detect duplication of p. D835, p. 1836, using mononuclear cells, reported as detection or non-detect duplication or against the use of midostaurin Prior authorization is required. 0026U Oncology (thyroid), DNA and mRNA of 112 genes, next generation sequence), fine needle as detection or non-detect diporties, fine needle aspirate of thyroid nodue, algorithmic analysis reported as a categorical result ("Positive, high probability of malignancy") Prior authorization is required. 0027U JAK2 (Janus kinase 2) (eg, myeloproliferative disorder) gene analysis expected sequence analysis (ife, CYP1A2, CYP2A2, CYP2A3, CYP2A3, CYP4A2, CYP4A3, CYP4A2, SUAA, CYPA43, CYP4A2, SUAA, CYP4A3, CYP4A2, SUAA, CYP4A3, CYP4A2, SUAA, CYP4A3, CYP4A2, SUCAB1, and response), targeted sequence analysis (ife, CYP2A), CYP2A2, CYP2C9, CYP4A2, CYP4A3, CYP4A2, SUAA, CYP
0022U analysis, 23 genes, interogation for sequence variants and rearrangements, reported as presence or variants and associated therapy(ies) to consider reported on sociated therapy(ies) to consider reported as discociated as discocia
0022U analysis, 23 genes, interogation for sequence variants and rearrangements, reported as presence or absence of variants and associated therapy(ies) to consider Prior authorization is required. 0023U Oncology (acute myelogenous leukemia), DNA, genotyping of internal tandem duplication, p.D835, p.1836, using mononuclear cells, reported as detection or non-detection of FLT3 mutation and indication for or against the use of midostation Prior authorization is required. 0026U Oncology (introduce), algorithmic analysis reported as a categorical result ("Positive, high probability of malignancy" or "Negative, low probability of malignancy") Prior authorization is required. 0027U JAK2 (anus kinase 2) (eg, myeloproliferative disorder) gene analysis, targeted sequence analysis (ie, CYPL2), CYP2G, CYP2G
Image: Process of variants and associated therapy(ies) to consider Prior authorization is required. 00230 Oncology (acute myelogenous leukemia), DNA, genotyping of internal tande duplication, p.D835, p.1836, using monouclear cells, reported as detection or non-detection of F13 mutation and indication for or against the use of midostaurin Prior authorization is required. 002600 Spriate Giventian and MRA of 112 genes, next generation sequencing, fine needle aspirate of hyroid nodule, algorithmic analysis reported as a ceteportical result ("Positive, high probability of malignancy" or "Negative, low probability of malignancy") Prior authorization is required. 002700 JAK2 (Janus kinase 2) (eg., myeloproliferative disorder) gene analysis, targeted sequence analysis (exon 12-15 construction is required. Prior authorization is required. 002900 Drug metabolism (daverse drug reactions and drug response), targeted sequence analysis (exon 12-15 construction is required. Prior authorization is required. 003000 Drug metabolism (warfarin drug response), targeted sequence analysis (exon 12-15 construction is required. Prior authorization is required. 003000 Drug metabolism (warfarin drug response), targeted sequence analysis (exon 12-15 construction is required. Prior authorization is required. 003000 Drug metabolism (warfarin drug response), targeted sequence analysis (exon 12-15 construction is required. Prior authorization is required. 002110 CVP1A2 (vtochrome P450 family 1, subfamily 4, me
Oncology (acute myelogenous leukemia), DNA, genotyping of internal tandem duplication, p. D835, p.1836, using mononuclear cells, reported as detection or non-detection of FLT3 Prior authorization is required. Oncology (thyroid), DNA and mRNA of 112 genes, next-generation sequencing, fine needle aspirate of thyroid nodule, algorithmic analysis reported as a categorical result ("Positive, high probability of malignancy" or "Negative, low probability of malignancy") Prior authorization is required. 0027U JAK2 (Janus Kinase 2) (eg, myeloproliferative disorder) gene analysis, targeted sequence analysis (eg, cryeloproliferative disorder) gene analysis, targeted sequence analysis (eg, cryeloproliferative disorder) gene analysis, targeted sequence analysis (eg, cryeloproliferative disorder) gene analysis, targeted sequence analysis Prior authorization is required. 0029U IAK2 (PriA2, CYP2G), CYP2G, CYP2G, SLC01BI, VKORC1 and rs12777823) Prior authorization is required. 0030U Drug metabolism (warfarin drug response), targeted sequence analysis (eg, CYP2G), CYP2G, VFA2, SLC01BI, VKORC1 and rs12777823) Prior authorization is required. 0031U CYP1A2, (CYP2G), CYP2G, CYP2G, CYP2G, Prior analysis, fie, CYP2G,
0023U p.D835, p.1836, using mononuclear cells, reported as detection or non-detection of FLT3 mutation and indication for or against the use of midostation 00020fU Prior authorization is required. Prior authorization is required. 00220U apprate of thyroid nowal, algorithmic analysis reported as a categorical result ("Positive, high probability of malignancy") or "Negative, low probability of malignancy" Prior authorization is required. Prior authorization is required. 00227U JAK2 (Janus kinase 2) (eg, myeloproliferative disorder) gene analysis, tageted sequence analysis exons 12-15 (ie, CYP1A2, CYP2C9,
Impact Number of Strength I
Oncology (thyroid), DNA and mRNA of 112 genes, next-generation sequencing, fine needle Prior authorization is required. 0026U aspirate of thyroid nodule, algorithmic analysis reported as a categorical result ("Positive, high probability of malignancy" or "Negative, low probability of malignancy") Prior authorization is required. 0027U JAK2 (Janus kinase 2) (eg. myeloproliferative disorder) gene analysis, targeted sequence analysis Prior authorization is required. 0029U Like (CYPLA2, CYP2CI9, CYP2G), CYP2G), CYP2G, CYP2G, SLCOBL, VKORC1 and rs12777823) Prior authorization is required. 0030U Drug metabolism (warfarin drug response), targeted sequence analysis (e, CYP2G), CYP4E2, VKORC1, rs12777823) Prior authorization is required. 00231U CYP1A2 (cytochrome P450 family 1, subfamily 4, member 2) (eg, drug metabolism gene Prior authorization is required.
0026U aspirate of thyroid nodule, algorithmic analysis reported as a categorical result ("Positive, high probability of malignancy") Prior authorization is required. 0027U JAC2 (Janus kinase 2) (eg, myeloproliferative disorder) gene analysis, targeted sequence analysis (eg, myeloproliferative disorder) gene analysis, targeted sequence analysis (ie, CYP2G), CYP2G, CY
high probability of malignancy" or "Negative, low probability of malignancy") Prior authorization is required. 0027U JAK2 (Janus kinase 2) (eg, myeloproliferative disorder) gene analysis, targeted sequence analysis exons 12-15 Prior authorization is required. 0029U Drug metabolism (adverse drug reactions and drug response), targeted sequence analysis (ie, CYP1A2, CYP2C19, CYP2C9, CYP2A4, CYP3A5, CYP4F2, SLC01B1, VKORC1 and rs12777823) Prior authorization is required. 0030U Drug metabolism (warfarin drug response), targeted sequence analysis (ie, CYP2C9, CYP2A2), CYP4F2, VKORC1, rs1277823) Prior authorization is required. 0031U CYP1A2 (cytochrome P450 family 1, subfamily 4, member 2) (eg, drug metabolism) gene Prior authorization is required.
0027U JAK2 (Janus kinase 2) (eg, myeloproliferative disorder) gene analysis, targeted sequence analysis exons 12-15 Prior authorization is required. 0029U Drug metabolism (adverse drug response), targeted sequence analysis (ic, CYP1A2, CYP2C9, CYP2C9, CYP2C9, CYP2C9, CYP2C9, CYP2A2, CYP3A3, CYP3A5, CYP4F2, SLC01B1, VKORC1 and rs12777823) Prior authorization is required. 0030U Drug metabolism (warfarin drug response), targeted sequence analysis (ie, CYP2C9, CYP4F2, VKORC1, rs12777823) Prior authorization is required. 0031U CYP1A2 (cytochrome P450 family 1, subfamily 4, member 2) (eg, drug metabolism) gene Prior authorization is required.
OD2/0 analysis exons 12-15 Prior authorization is required. D029U Drug metabolism (adverse drug reactions and drug response), targeted sequence analysis (ie, CYP1A2, CYP2C9, CYP2
Image: Constraint of the second se
0029U (ie, CYP1A2, CYP2C19, CYP2D6, CYP3A4, CYP3A5, CYP3
Image: Note of the state of
Image: Note of the second s
D030U Drug metabolism (warfarin drug response), targeted sequence analysis (ie, CYP2C9, CYP4F2, VKORC1, rs12777823) Prior authorization is required. D021U CYP1A2 (cytochrome P450 family 1, subfamily A, member 2) (eg, drug metabolism) gene Prior authorization is required.
U0300 CYP4F2, VKORC1, rs12777823) Prior authorization is required. 002111 CYP1A2 (cytochrome P450 family 1, subfamily A, member 2) (eg, drug metabolism) gene Prior authorization is required.
CVP1A2 (cytochrome P450 family 1, subfamily A, member 2) (eg. drug metabolism) gene Brior authorization is required
analysis, common variants (ie, *1F, *1K, *6, *7)
COMT (estache) O mothyltransforsca) (ag daus metabolism) gang analysis c 472654
COMT (catechol-O-methyltransferaes) (eg. drug metabolism) gene analysis, c.472G>A Prior authorization is required.
(r\$4680) vanant
HTR2A (5-hydroxytryptamine receptor 2A), HTR2C (5-hydroxytryptamine receptor 2C) (eg,
0033U citalopram metabolism) gene analysis, common variants (ie, HTR2A rs7997012 [c.614- Prior authorization is required.
2211T>C], HTR2C r53813929 [c-759C>T] and r51414334 [c.551-3008C>G])
TPMT (thiopurine S-methyltransferase), NUDT15 (nudik hydroxylase 15) (eg, thiopurine
0034U metabolism) gene analysis, common variants (ie, TPMT *2, *3A, *3B, *3C, *4, *5, *6, *8, Prior authorization is required.
*12; NUDT15 *3, *4, *5)
Exome (ie, somatic mutations), paired formalin-fixed paraffin-embedded tumor tissue and
popiciti Exone (ie) somate initiations), paret romanimized paraminentoe ded tumor ussue and
0036U Exome (le, soma ce mutatoris), paired formalin-free paratim-embedded tumor tissue and normal specimen, sequence analyses Prior authorization is required.
UU360 normal specimen, sequence analyses Prior authorization is required.
UU3bU normal specimen, sequence analyses Prior authorization is required. Targeted genomic sequence analysis, solid organ neoplasm, DNA analysis of 324 genes,
U0360 normal specimen, sequence analyses Prior authorization is required. 00370 Targeted genomic sequence analysis, solid organ neoplasm, DNA analysis of 324 genes, interrogation for sequence variants, gene copy number amplifications, gene Prior authorization is required.
U03b0 normal specimen, sequence analyses Prior authorization is required. 0037U Targeted genomic sequence analysis, solid organ neoplasm, DNA analysis of 324 genes, interrogation for sequence variants, gene copy number amplifications, gene rearrangements, microsatellite instability and tumor mutational burden Prior authorization is required. 0037U 60/04/11 (10/231)(ac, declarations) (ac adjustic main Prior authorization is required.
U0360 normal specimen, sequence analyses Prior authorization is required. 00370 Targeted genomic sequence analysis, solid organ neoplasm, DNA analysis of 324 genes, interrogation for sequence variants, gene copy number amplifications, gene rearrangements, microsatellite instability and tumor mutational burden Prior authorization is required. 004011 BCR/ABL1 (1(9;22)) (eg, chronic myelogenous leukemia) translocation analysis, major Prior authorization is required.
U0360 normal specimen, sequence analyses Prior authorization is required. 00370 Targeted genomic sequence analysis, solid organ neoplasm, DNA analysis of 324 genes, interrogation for sequence variants, gene copy number amplifications, gene rearrangements, microsatellite instability and tumor mutational burden Prior authorization is required.

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	Oncology (breast ductal carcinoma in situ), mRNA, gene expression profiling by real-time			
0045U	RT-PCR of 12 genes (7 content and 5 housekeeping), utilizing formalin-fixed paraffin-	Prior authorization is required.		
	embedded tissue, algorithm reported as recurrence score			
0046U	FLT3 (fms-related tyrosine kinase 3) (eg, acute myeloid leukemia) internal tandem	Prior authorization is required.		
00400	duplication (ITD) variants, quantitative	The automation stepared.		
	Oncology (prostate), mRNA, gene expression profiling by real-time RT-PCR of 17 genes (12			
0047U	content and 5 housekeeping), utilizing formalin-fixed paraffin-embedded tissue, algorithm	Prior authorization is required.		
	reported as a risk score			
	Oncology (solid organ neoplasia), DNA, targeted sequencing of protein-coding exons of 468			
004011	cancer-associated genes, including interrogation for somatic mutations and microsatellite			
0048U	instability, matched with normal specimens, utilizing formalin-fixed paraffin-embedded	Prior authorization is required.		
	tumor tissue, report of clinically significant mutation(s)			
0049U	NPM1 (nucleophosmin) (eg, acute myeloid leukemia) gene analysis, quantitative	Prior authorization is required.		
0050U	Targeted genomic sequence analysis panel, acute myelogenous leukemia, DNA analysis,	Prior authorization is required.		
	194 genes, interrogation for sequence variants, copy number variants or rearrangements			
	Oncology (prostate cancer), FISH analysis of 4 genes (ASAP1, HDAC9, CHD1 and PTEN),			
0053U	needle biopsy specimen, algorithm reported as probability of higher tumor grade	Prior authorization is required.		
	Cardiology (heart transplant), cell-free DNA, PCR assay of 96 DNA target sequences (94			
0055U	single nucleotide polymorphism targets and two control targets), plasma	Prior authorization is required.		
	Twin zygosity, genomic-targeted sequence analysis of chromosome 2, using circulating cell-			
0060U	free fetal DNA in maternal blood	Prior authorization is required.		
	Candida species panel (C. albicans, C. glabrata, C. parapsilosis, C. kruseii, C. tropicalis and C.			
0068U	auris), amplified probe technique with qualitative report of the presence or absence of each	Prior authorization is required.		
00000	species	i noi autorization si required.		
	Candida species panel (C. albicans, C. glabrata, C. parapsilosis, C. kruseii, C. tropicalis and C.		1	
0069U	auris), amplified probe technique with qualitative report of the presence or absence of each	Prior authorization is required.		
00050	species	ritor autionzation is required.		
	CYP2D6 (cytochrome P450, family 2, subfamily D, polypeptide 6) (eg, drug metabolism)			
0070U	gene analysis, common and select rare variants (ie, *2, *3, *4, *4N, *5, *6, *7, *8, *9, *10,	Prior authorization is required.		
	*11, *12, *13, *14A, *14B, *15, *17, *29, *35, *36, *41, *57, *61, *63, *68, *83, *xN)			
	CYP2D6 (cytochrome P450, family 2, subfamily D, polypeptide 6) (eg, drug metabolism)			
0071U	gene analysis, full gene sequence (List separately in addition to code for primary	Prior authorization is required.		
00/10	gene analysis, full gene sequence (List separately in addition to code for primary procedure)	Prior authorization is required.		
007211	CYP2D6 (cytochrome P450, family 2, subfamily D, polypeptide 6) (eg, drug metabolism)			
0072U	gene analysis, targeted sequence analysis (ie, CYP2D6-2D7 hybrid gene) (List separately in	Prior authorization is required.		
	addition to code for primary procedure)			
007211	CYP2D6 (cytochrome P450, family 2, subfamily D, polypeptide 6) (eg, drug metabolism)			
0073U	gene analysis, targeted sequence analysis (ie, CYP2D7-2D6 hybrid gene) (List separately in	Prior authorization is required.		
	addition to code for primary procedure)			
	CYP2D6 (cytochrome P450, family 2, subfamily D, polypeptide 6) (eg, drug metabolism)			
0074U	gene analysis, targeted sequence analysis (ie, non-duplicated gene when	Prior authorization is required.		
	duplication/multiplication is trans) (List separately in addition to code for primary			
	procedure)			
	CYP2D6 (cytochrome P450, family 2, subfamily D, polypeptide 6) (eg, drug metabolism)			
00750	gene analysis, targeted sequence analysis (ie, 5' gene duplication/multiplication) (List	Prior authorization is required.		
	separately in addition to code for primary procedure)			
	CYP2D6 (cytochrome P450, family 2, subfamily D, polypeptide 6) (eg, drug metabolism)			
0076U	gene analysis, targeted sequence analysis (ie, 3' gene duplication/multiplication) (List	Prior authorization is required.		
	separately in addition to code for primary procedure)			
	Pain management (opioid-use disorder) genotyping panel, 16 common variants (ie, ABCB1,			
0078U	COMT, DAT1, DBH, DOR, DRD1, DRD2, DRD4, GABA, GAL, HTR2A, HTTLPR, MTHFR, MUOR,	Prior authorization is required.		
	OPRK1, OPRM1), buccal swab or other germline tissue sample, algorithm reported as			
	positive or negative risk of opioid-use disorder			
0079U	Comparative DNA analysis using multiple selected single-nucleotide polymorphisms	Prior authorization is required.		
00,50	(SNPs), urine and buccal DNA, for specimen identity verification	inter automation is required.		
0084U	Red blood cell antigen typing, DNA, genotyping of 10 blood groups with phenotype	Prior authorization is required.		
00040	prediction of 37 red blood cell antigens	The automation srequires.		
	Infectious disease (bacterial and fungal), organism identification, blood culture, using rRNA			
0086U	FISH, 6 or more organism targets, reported as positive or negative with phenotypic	Prior authorization is required.		
	minimum inhibitory concentration (MIC)-based antimicrobial susceptibility			
	Cardiology (heart transplant), mRNA gene expression profiling by microarray of 1283			
0087U	genes, transplant biopsy tissue, allograft rejection and injury algorithm reported as a	Prior authorization is required.		
	probability score			
	Transplantation medicine (kidney allograft rejection), microarray gene expression profiling			
0088U	of 1494 genes, utilizing transplant biopsy tissue, algorithm reported as a probability score	Prior authorization is required.		
	for rejection			
0089U	Oncology (melanoma), gene expression profiling by RTqPCR, PRAME and LINC00518,	Prior authorization is required.		
00090	superficial collection using adhesive patch(es)	ritor autionzation is required.	l	

0090U	Oncology (cutaneous melanoma), mRNA gene expression profiling by RT-PCR of 23 genes (14 content and 9 housekeeping), utilizing formalin-fixed paraffin-embedded (FFPE) tissue, algorithm reported as a categorical result (ie, benign, intermediate, malignant)	Prior authorization is required.	
0094U	Oncology (colorectal) screening, cell enumeration of circulating tumor cells, utilizing whole blood, algorithm, for the presence of adenoma or cancer, reported as a positive or negative result	Prior authorization is required.	
0095T	Removal of total disc arthroplasty (artificial disc), anterior approach, each additional interspace, cervical (List separately in addition to code for primary procedure)	Prior authorization is managed by EviCore.	Prior authorization is managed by EviCore.
00960	Oncology (colorectal) screening, cell enumeration of circulating tumor cells, utilizing whole blood, algorithm, for the presence of adenoma or cancer, reported as a positive or negative result	Prior authorization is required.	
0098T	Revision including replacement of total disc arthroplasty (artificial disc), anterior approach, each additional interspace, cervical (List separately in addition to code for primary procedure)	Prior authorization is managed by EviCore.	Prior authorization is managed by EviCore.
0101U	Hereditary colon cancer disorders (eg, Lynch syndrome, PTEN hamartoma syndrome, Cowden syndrome, familial adenomatosis polyposis), genomic sequence analysis panel utilizing a combination of NGS, Sanger, MLPA and array CGH, with mRNA analytics to resolve variants of unknown significance when indicated (15 genes [sequencing and deletion/duplication], EPCAM and GREM1 [deletion/duplication only])	Prior authorization is required.	
0102U	Hereditary breast cancer-related disorders (eg, hereditary breast cancer, hereditary ovarian cancer, hereditary endometrial cancer), genomic sequence analysis panel utilizing a combination of NGS, Sanger, MLPA and array CGH, with mRNA analytics to resolve variants of unknown significance when indicated (17 genes [sequencing and deletion/duplication])	Prior authorization is required.	
0103U	Hereditary ovarian cancer (eg, hereditary ovarian cancer, hereditary endometrial cancer), genomic sequence analysis panel utilizing a combination of NGS, Sanger, MLPA and array CGH, with mRNA analytics to resolve variants of unknown significance when indicated (24 genes [sequencing and deletion/duplication], EPCAM [deletion/duplication only]}	Prior authorization is required.	
01050	Nephrology (chronic kidney disease), multiplex electrochemiluminescent immunoassay (ECLIA) of tumor necrosis factor receptor 1A, receptor superfamily 2 (TNFR1, TNFR2) and kidney injury molecule-1 (KIM-1) combined with longitudinal clinical data, including APOL1 genotype if available and plasma (isolated fresh or frozen), algorithm reported as probability score for rapid kidney function decline (RKFD)	Prior authorization is required.	
0109U	Infectious disease (Aspergillus species), real-time PCR for detection of DNA from 4 species (A. fumigatus, A. terreus, A. niger and A. flavus), blood, lavage fluid, or tissue, qualitative reporting of presence or absence of each species	Prior authorization is required.	
0111U	Oncology (colon cancer), targeted KRAS (codons 12, 13 and 61) and NRAS (codons 12, 13 and 61) gene analysis, utilizing formalin-fixed paraffin-embedded tissue	Prior authorization is required.	
0112U	Infectious agent detection and identification, targeted sequence analysis (16S and 18S rRNA genes) with drug-resistance gene	Prior authorization is required.	
0113U	Oncology (prostate), measurement of PCA3 and TMPRSS2-ERG in urine and PSA in serum following prostatic massage, by RNA amplification and fluorescence-based detection, algorithm reported as risk score	Prior authorization is required.	
0114U	Gastroenterology (Barrett's esophagus), VIM and CCNA1 methylation analysis, esophageal cells, algorithm reported as likelihood for Barrett's esophagus	Prior authorization is required.	
0118U	Transplantation medicine, quantification of donor-derived cell-free DNA using whole genome next-generation sequencing, plasma, reported as percentage of donor-derived cell- free DNA in the total cell-free DNA	Prior authorization is required.	
0120U	Oncology (B-cell lymphoma classification), mRNA, gene expression profiling by fluorescent probe hybridization of 58 genes (45 content and 13 housekeeping genes), formalin-fixed paraffin-embedded tissue, algorithm reported as likelihood for primary mediastinal B-cell lymphoma (PMBCL) and diffuse large B-cell hymphoma (DLBCL) with cell of origin subtyping in the latter	Prior authorization is required.	
0129U	Hereditary breast cancer-related disorders (eg, hereditary breast cancer, hereditary ovarian cancer, hereditary endometrial cancer), genomic sequence analysis and deletion/duplication analysis panel (ATM, BRCA1, BRCA2, CDH1, CHEK2, PALB2, PTEN and TP53)	Prior authorization is required.	
0130U	Hereditary colon cancer disorders (eg, Lynch syndrome, PTEN hamartoma syndrome, Cowden syndrome, familial adenomatosis polyposis), targeted mRNA sequence analysis panel (APC, CDH1, CHEX2, MLH1, MSH2, MSH6, MUTYH, PMS2, PTEN and TPS3) (List separately in addition to code for primary procedure)	Prior authorization is required.	
0131U	Hereditary breast cancer-related disorders (eg, hereditary breast cancer, hereditary ovarian cancer, hereditary endometrial cancer), targeted mRNA sequence analysis panel (13 genes) (List separately in addition to code for primary procedure)	Prior authorization is required.	
0132U	Hereditary ovarian cancer-related disorders (eg, hereditary breast cancer, hereditary ovarian cancer, hereditary endometrial cancer), targeted mRNA sequence analysis panel (17 genes) (List separately in addition to code for primary procedure)	Prior authorization is required.	
0133U	Hereditary prostate cancer-related disorders, targeted mRNA sequence analysis panel (11 genes) (List separately in addition to code for primary procedure)	Prior authorization is required.	

0134U	Hereditary pan cancer (eg, hereditary breast and ovarian cancer, hereditary endometrial cancer, hereditary colorectal cancer), targeted mRNA sequence analysis panel (18 genes) (List separately in addition to code for primary procedure)	Prior authorization is required.	
0135U	Hereditary gynecological cancer (eg, hereditary breast and ovarian cancer, hereditary endometrial cancer, hereditary colorectal cancer), targeted mRNA sequence analysis panel (12 genes) (List separately in addition to code for primary procedure)	Prior authorization is required.	
0136U	ATM (ataxia telangiectasia mutated) (eg, ataxia telangiectasia) mRNA sequence analysis (List separately in addition to code for primary procedure)	Prior authorization is required.	
0137U	PALB2 (partner and localizer of BRCA2) (eg, breast and pancreatic cancer) mRNA sequence analysis (List separately in addition to code for primary procedure)	Prior authorization is required.	
0138U	BRCA1 (BRCA1, DNA repair associated), BRCA2 (BRCA2, DNA repair associated) (eg, hereditary breast and ovarian cancer) mRNA sequence analysis (List separately in addition to code for primary procedure)	Prior authorization is required.	
0140U	Infectious disease (fungi), fungal pathogen identification, DNA (15 fungal targets), blood culture, amplified probe technique, each target reported as detected or not detected	Prior authorization is required.	
0141U	Infectious disease (bacteria and fungi), gram-positive organism identification and drug resistance element detection, DNA (20 gram-positive bacterial targets, 4 resistance genes, 1 pan gram-negative bacterial target, 1 pan Candida target), blood culture, amplified probe technique, each target reported as detected or not detected	Prior authorization is required.	
0142U	Infectious disease (bacteria and fungi), gram-negative bacterial identification and drug resistance element detection, DNA (21 gram-negative bacterial targets, 6 resistance genes, 1 pan gram-positive bacterial target, 1 pan Candida target), amplified probe technique, each target reported as detected or not detected	Prior authorization is required.	
01520	Infectious disease (bacteria, fungi, parasites and DNA viruses), microbial cell-free DNA, plasma, untargeted next-generation sequencing, report for significant positive pathogens	Prior authorization is required.	
0153U	Oncology (breast), mRNA, gene expression profiling by next-generation sequencing of 101 genes, utilizing formalin-fixed paraffin-embedded tissue, algorithm reported as a triple negative breast cancer clinical subtype(s) with information on immune cell involvement	Prior authorization is required.	
0154U	Oncology (urothelial cancer), RNA, analysis by real-time RT-PCR of the FGFR3 (fibroblast growth factor receptor 3) gene analysis (ie, p.R248C [c.742C>T], p.S249C [c.746C>G], p. G370C [c.1108G>T], p.Y372 [c.1118A>G], FGFR3-TACC3V1 and FGFR3-TACC3V3), utilizing formalin-fixed paraffin-embedded urothelial cancer tumor tissue, reported as FGFR gene alteration status	Prior authorization is required.	
01550	Oncology (breast cancer), DNA, PIK3CA (phosphatidylinositol-4,5-bisphosphate 3-kinase, catalytic subunit alpha) (eg, breast cancer) gene analysis (ie, p. C420R, p. E542K, p. E545A, p. E545D [g. 1635G>T only], p. E545O, p. E545K, p. C346E, p. C346B, p. H1047L, p. H1047R, p. H1047Y), utilizing formalin-fixed paraffin-embedded breast tumor tissue, reported as PIK3CA gene mutation status	Prior authorization is required.	
0156U	Copy number (eg, intellectual disability, dysmorphology), sequence analysis	Prior authorization is required.	
01570	APC (APC regulator of WNT signaling pathway) (eg, familial adenomatosis polyposis [FAP]) mRNA sequence analysis (List separately in addition to code for primary procedure)	Prior authorization is required.	
0158U	MLH1 (mutL homolog 1) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) mRNA sequence analysis (List separately in addition to code for primary procedure)	Prior authorization is required.	
0159U	MSH2 (mutS homolog 2) (eg, hereditary colon cancer, Lynch syndrome) mRNA sequence analysis (List separately in addition to code for primary procedure)	Prior authorization is required.	
0160U	MSH6 (mutS homolog 6) (eg, hereditary colon cancer, Lynch syndrome) mRNA sequence analysis (List separately in addition to code for primary procedure)	Prior authorization is required.	
0161U	PMS2 (PMS1 homolog 2, mismatch repair system component) (eg, hereditary non- polyposis colorectal cancer, Lynch syndrome) mRNA sequence analysis (List separately in addition to code for primary procedure)	Prior authorization is required.	
0162U	Hereditary colon cancer (Lynch syndrome), targeted mRNA sequence analysis panel (MLH1, MSH2, MSH6, PMS2) (List separately in addition to code for primary procedure)	Prior authorization is required.	
0163T	Total disc arthroplasty (artificial disc), anterior approach, including discectomy to prepare interspace (other than for decompression), each additional interspace, lumbar (List separately in addition to code for primary procedure)	Prior authorization is managed by EviCore.	Prior authorization is managed by EviCore.
0164T	Removal of total disc arthroplasty, (artificial disc), anterior approach, each additional interspace, lumbar (List separately in addition to code for primary procedure)	Prior authorization is managed by EviCore.	Prior authorization is managed by EviCore.
0165T	Revision including replacement of total disc arthroplasty (artificial disc), anterior approach, each additional interspace, lumbar (List separately in addition to code for primary procedure)	Prior authorization is managed by EviCore.	Prior authorization is managed by EviCore.
01690	NUDT15 (nudix hydrolase 15) and TPMT (thiopurine S-methyltransferase) (eg, drug metabolism) gene analysis, common variants	Prior authorization is required.	
01700	Neurology (autism spectrum disorder [ASD]), RNA, next-generation sequencing, saliva, algorithmic analysis and results reported as predictive probability of ASD diagnosis	Prior authorization is required.	
0171U	Targeted genomic sequence analysis panel, acute myeloid leukemia, myelodysplastic syndrome and myeloproliferative neoplasms, DNA analysis, 23 genes, interrogation for sequence variants, rearrangements and minimal residual disease, reported as presence/absence	Prior authorization is required.	

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 mologous recombination deficiency pathways, DNA, formalin-fixed paraffin-embedded			
	Prior authorization is required.		
tissue, algorithm quantifying tumor genomic instability score			
ychiatry (ie, depression, anxiety), genomic analysis panel, includes variant analysis of 14 genes	Prior authorization is required.		
ychiatry (eg, depression, anxiety), genomic analysis panel, variant analysis of 15 genes	Prior authorization is required.		
ncology (breast cancer), DNA, PIK3CA (phosphatidylinositol-4,5-bisphosphate 3-kinase catalytic subunit alpha) gene analysis of 11 gene variants utilizing plasma, reported as PIK3CA gene mutation status	Prior authorization is required.		
Dncology (non-small cell lung cancer), cell-free DNA, targeted sequence analysis of 23 genes (single nucleotide variations, insertions and deletions, fusions without prior knowledge of partner/breakpoint, copy number variations), with report of significant mutation(s)	Prior authorization is required.		
Red cell antigen (ABO blood group) genotyping (ABO), gene analysis Sanger/chain termination/conventional sequencing, ABO (ABO, alpha 1-3-N- acetylgalactosaminyltransferase and alpha 1-3-galactosyltransferase) gene, including subtyping, 7 exons	Prior authorization is required.		
ed cell antigen (Colton blood group) genotyping (CO), gene analysis, AQP1 (aquaporin 1 [Colton blood group]) exon 1	Prior authorization is required.		
Red cell antigen (Cromer blood group) genotyping (CROM), gene analysis, CD55 (CD55 molecule [Cromer blood group]) exons 1-10	Prior authorization is required.		
d cell antigen (Diego blood group) genotyping (DI), gene analysis, SLC4A1 (solute carrier family 4 member 1 [Diego blood group]) exon 19	Prior authorization is required.		
Red cell antigen (Dombrock blood group) genotyping (DO), gene analysis, ART4 (ADP- ribosyltransferase 4 [Dombrock blood group]) exon 2	Prior authorization is required.		
Red cell antigen (H blood group) genotyping (FUT1), gene analysis, FUT1 (fucosyltransferase 1 [H blood group]) exon 4	Prior authorization is required.		
Red cell antigen (H blood group) genotyping (FUT2), gene analysis, FUT2 (fucosyltransferase 2) exon 2	Prior authorization is required.		
Red cell antigen (Duffy blood group) genotyping (FY), gene analysis, ACKR1 (atypical chemokine receptor 1 [Duffy blood group]) exons 1-2	Prior authorization is required.		
d cell antigen (Gerbich blood group) genotyping (GE), gene analysis, GYPC (glycophorin C [Gerbich blood group]) exons 1-4	Prior authorization is required.		
d cell antigen (MNS blood group) genotyping (GYPA), gene analysis, GYPA (glycophorin A [MNS blood group]) introns 1, 5, exon 2	Prior authorization is required.		
d cell antigen (MNS blood group) genotyping (GYPB), gene analysis, GYPB (glycophorin B [MNS blood group]) introns 1, 5, pseudoexon 3	Prior authorization is required.		
d cell antigen (Indian blood group) genotyping (IN), gene analysis, CD44 (CD44 molecule [Indian blood group]) exons 2, 3, 6	Prior authorization is required.		
d cell antigen (Kidd blood group) genotyping (JK), gene analysis, SLC14A1 (solute carrier family 14 member 1 [Kidd blood group]) gene promoter, exon 9	Prior authorization is required.		
Red cell antigen (JR blood group) genotyping (JR), gene analysis, ABCG2 (ATP binding cassette subfamily G member 2 [Junior blood group]) exons 2-26	Prior authorization is required.		
Red cell antigen (Kell blood group) genotyping (KEL), gene analysis, KEL (Kell metallo-	Prior authorization is required.		
KLF1 (Kruppel-like factor 1), targeted sequencing (ie, exon 13)	Prior authorization is required.		
ed cell antigen (Lutheran blood group) genotyping (LU), gene analysis, BCAM (basal cell adhesion molecule [Lutheran blood group]) exon 3	Prior authorization is required.		
d cell antigen (Landsteiner-Wiener blood group) genotyping (LW), gene analysis, ICAM4 (intercellular adhesion molecule 4 [Landsteiner-Wiener blood group]) exon 1	Prior authorization is required.		
d cell antigen (RH blood group) genotyping (RHD and RHCE), gene analysis Sanger/chain remination/conventional sequencing, RHD (Rh blood group D antigen) exons 1-10 and RHCE (Rh blood group CcEe antigens) exon 5	Prior authorization is required.		
Red cell antigen (Scianna blood group) genotyping (SC), gene analysis, ERMAP (erythroblast membrane associated protein [Scianna blood group]) exons 4, 12	Prior authorization is required.		
Red cell antigen (Kx blood group) genotyping (XK), gene analysis, XK (X-linked Kx blood group) exons 1-3	Prior authorization is required.		
Red cell antigen (Yt blood group) genotyping (YT), gene analysis, ACHE (acetylcholinesterase [Cartwright blood group]) exon 2	Prior authorization is required.		
Autoimmune (inflammatory bowel disease), mRNA, gene expression profiling by antitative RT-PCR, 17 genes (15 target and 2 reference genes), whole blood, reported as continuous risk score and classification of inflammatory bowel disease aggressiveness	Prior authorization is required.		
Incology (thyroid), mRNA, gene expression analysis of 593 genes (including BRAF, RAS, RET, PAX8 and NTRK) for sequence variants and rearrangements, utilizing fine needle aspirate, reported as detected or not detected	Prior authorization is required.		
iphthalmology (age-related macular degeneration), analysis of 3 gene variants (2 CFH gene, 1 ARMS2 gene), using PCR and MALDI-TOF, buccal swab, reported as positive or negative for neovascular age-related macular-degeneration risk associated with zinc supplements	Prior authorization is required.		
	chlatty (eg, depression, anxiety), genomic analysis panel, variant analysis of 15 genes cology (breast cancer), DNA, PIK3CA (phosphatidylinositol-4,5-bisphosphate 3-kinase talytic subunit alpha) gene analysis of 11 gene variants utilizing plasma, reported as PIK3CA gene mutation status noology (non-small cell lung cancer), cell-free DNA, targeted sequence analysis of 23 genes (isrigle nucleotide variations, insertions and deletions, fusions without prior nowledge of partner/breakpoint, copy number variations), with report of significant mutation(5) Red cell antigen (ABO blood group) genotyping (ABO), gene analysis Sanger/chain termination/conventional sequencing, ABO (ABO, alpha 1-3-N+ cety[galactosaminyltransferase and alpha 1-3 galactosyltransferase) gene, including subtyping, 7 exons 1 cell antigen (Colton blood group) genotyping (CROM), gene analysis, CD55 (CD55 molecule (Cromer blood group) genotyping (CBO), gene analysis, SLCAA1 (solute carrier family 4 member 1 [Diego blood group)] exons 1-10 cell antigen (Diego blood group) genotyping (FUT), gene analysis, SLCAA1 (solute carrier family 4 member 1 [Diego blood group)] exon 2 Red cell antigen (H blood group) genotyping (FUT), gene analysis, FUT1 (fucosyltransferase 1 [H blood group]) exon 4 Red cell antigen (H blood group) genotyping (FUT2), gene analysis, FUT2 (fucosyltransferase 1 [Diblod group]) exon 4 Red cell antigen (Gerbich blood group)] exon 51-4 cell antigen (Gerbich blood group) genotyping (FVR), gene analysis, GYPC (glycophorin C [Gerbich blood group] genotyping (FVR), gene analysis, GYPC (glycophorin C [Gerbich blood group]) exon 51-5, seudoexon 3 (MNS blood group)] exon 51, 5, seudoexon 3. cell antigen (MMS blood group) genotyping (FVR), gene analysis, GYPA (glycophorin B [MNS blood group]) genotyping (FVR), gene analysis, GYPA (glycophorin B [MNS blood group]) genotyping (FVR), gene analysis, GYPA (glycophorin B [MNS blood group]) genotyping (FVR), gene analysis, GYA4 (CD44 molecule [Indian blood group] genotyping (FVR), gene analysis, GYA6	agenci agenci	App of partial structure App of partial structure App of partial structure App of partial structure Perform all formation in required. App of partial structure App of part partial structure App of partial

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Image:	02500	exonic and intronic regions, deletions, duplications, short tandem repeat (STR) expansions,	Prior autionzation is required.		
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U2321 Description preparation when performed Prior authorization is required. Reference policies for additional information. healing Wounds in The Outpatient Setting 02320 CSE (cystatin B) (eg, progressive myoclonic epilepsy type 1A, Unverricht-Lundborg disease), full gene analysis, including small sequence changes in exonic and intronic insertions and variants in non-uniquely mappable regions Prior authorization is required. Prior authorization is required. 023300 FXN (fratavia) (egn. Fridericht axia), gene analysis, including small sequence changes in exonic and intronic regions, deletions, duplications, short tandem repeat (STR) expansions, mobile element insertions and variants in non-uniquely mappable regions Prior authorization is required. 023300 MECP2 (methyl CpG binding protein 2) (eg, Rett syndrome), full gene analysis, including small sequence changes in exonic and intronic regions, deletions, duplications, short andem repeat (STR) expansions, mobile element insertions and variants in non-uniquely mappable regions Prior authorization is required. 023400 MECP2 (methyl CpG binding protein 2) (eg, Rett syndrome), full gene analysis, including small sequence changes in exonic and intronic regions, deletions, duplications, mobile element insertions and variants in non-uniquely mappable regions Prior authorization is required. 023400 MECP2 (methyl CpG binding protein 2) (eg, Rett syndrome), full gene analysis, including small sequence changes in exonic and intronic regions, dueltons, duplications, mobile element insertions and variants in non-uniquely mappable regions Prior authorization is required. 023410 SPEN (phospha				HHO DE MD 1122 Skin Ponlacoment Therapy For Chronic Ner	
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 tander mepeat (STR) expansions, mobile element insertions and variants in non-uniquely mappable regions Prior authorization is required. 0233U FXN (frataxin) (eg, Frédreich ataxia), gene analysis, including small sequence changes in exonic and intronic regions, deletions, duplications, short tander mepeat (STR) expansions, mobile element insertions, short tander mepeat (STR) expansions, mobile element insertions and variants in non-uniquely mappable regions Prior authorization is required. 0233U FXN (frataxin) (eg, Frédreich ataxia), gene analysis, including small sequence changes in exonic and intronic regions, deletions, duplications, short tander regions Prior authorization is required. 0234U MECP2 (methyl CpG binding protein 2) (eg, Rett syndrome), full gene analysis, including small sequence changes in exonic and intronic regions, deletions, duplications, mobile element insertions and variants in non-uniquely mappable regions Prior authorization is required. 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 issertions, and variants in non-uniquely mappable regions Prior authorization is required. 0234U MECP2 (methyl CpG binding protein 2) (eg, Rett syndrome, PTEN hamatoma tumor Prior authorization is required. 0235U PTEN (phosphatas and	0232T		Prior authorization is required. Reference policies for additional information.		
0232U disease), full gene analysis, including small sequence changes in exonic and intronic regions, deletions, duplications, short tandem repeat (STR) expansions, mobile element insertions and variants in non-uniquely mappable regions Prior authorization is required. 0233U FXN (frataxin) (eg., Friedreich ataxia), gene analysis, including small sequence changes in exonic and intronic regions, deletions, duplications, short tandem repeat (STR) expansions, mobile element insertions and variants in non-uniquely mappable regions Prior authorization is required. 0233U KECP2 (methyl CpG binding protein 2) (eg., Rett syndrome), full gene analysis, including small sequence changes in exonic and intronic regions, deletions, duplications, mobile element insertions and variants in non-uniquely mappable regions Prior authorization is required. 0234U MECP2 (methyl CpG binding protein 2) (eg., Rett syndrome), full gene analysis, including small sequence changes in exonic and intronic regions, deletions, duplications, mobile element insertions and variants in non-uniquely mappable regions Prior authorization is required. 0234U MECP2 (methyl CpG binding protein 2) (eg., Rett syndrome), FUE hamarton atumer syndrome, PTEN hamarton atumer syndrome		h . h		nearing wounds in the Outpatient Setting	
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PXN (frataxin) (eg, Friedreich ataxia), gene analysis, including small sequence changes in exonic and intronic regions, deletions, duplications, short tandem repeat (TR) expansions, mobile element insertions and variants in non-uniquely mappable regions Prior authorization is required. 0234U MCP22 (methyl CpG binding protein 2) (eg, Rett syndrome), full gene analysis, including small sequence changes in exonic and intronic regions, deletions, duplications, mobile element insertions and variants in non-uniquely mappable regions Prior authorization is required. 0234U MCP22 (methyl CpG binding protein 2) (eg, Rett syndrome), full gene analysis, including small sequence changes in exonic and intronic regions, deletions, duplications, mobile element insertions and variants in non-uniquely mappable regions Prior authorization is required. 0234U MCP22 (methyl CpG binding protein 2) (eg, Rett syndrome), FUEN hamatroma tumor syndrome), full gene analysis, including small sequence changes in exonic and intronic Prior authorization is required. 0235U Syndrome), full gene analysis, including small sequence changes in exonic and intronic Prior authorization is required.					
0233U exonic and intronic regions, deletions, duplications, short tandem repeat (STR) expansions, mobile element insertions and variants in non-uniquely mappable regions Prior authorization is required. 0234U MEC92 (methyl CGR) binding protein 2) (eg., Rett syndrome), full gene analysis, including small sequence changes in exonic and intronic regions, deletions, duplications, mobile element insertions and variants in non-uniquely mappable regions Prior authorization is required. 0234U PTEN (phosphatas and tensin homolog) (eg., Cowden syndrome, PTEN hamartom tumor syndrome), full gene analysis, including sin all sequence changes in exonic and intronic Prior authorization is required.					
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023511 syndrome), full gene analysis, including small sequence changes in exonic and intronic Prior authorization is required					
02350 regions, deletions, duplications, mobile element insertions and variants in non-uniquely Prior automization is required.	0235U		Prior authorization is required.		
mappable regions		mappable regions		1	

	SMN1 (survival of motor neuron 1, telomeric) and SMN2 (survival of motor neuron 2,		
0236U	centromeric) (eg, spinal muscular atrophy) full gene analysis, including small sequence	Prior authorization is required.	
	changes in exonic and intronic regions, duplications, deletions and mobile element insertions		
	insertions		
	Cardiac ion channelopathies (eg, Brugada syndrome, long QT syndrome, short QT		
	syndrome, catecholaminergic polymorphic ventricular tachycardia), genomic sequence		
0237U	analysis panel including ANK2, CASQ2, CAV3, KCNE1, KCNE2, KCNH2, KCNJ2, KCNQ1, RYR2	Prior authorization is required.	
	and SCN5A, including small sequence changes in exonic and intronic regions, deletions,		
	duplications, mobile element insertions and variants in non-uniquely mappable regions		
	Oncology (Lynch syndrome), genomic DNA sequence analysis of MLH1, MSH2, MSH6,		
022011	PMS2 and EPCAM, including small sequence changes in exonic and intronic regions,	Deine station is serviced	
0238U	deletions, duplications, mobile element insertions and variants in non-uniquely mappable	Prior authorization is required.	
	regions		
	Targeted genomic sequence analysis panel, solid organ neoplasm, cell-free DNA, analysis		
0239U	of 311 or more genes, interrogation for sequence variants, including substitutions,	Prior authorization is required.	
	insertions, deletions, select rearrangements and copy number variations		
	Targeted genomic sequence analysis panel, solid organ neoplasm, cell-free circulating DNA		
0242U	analysis of 55-74 genes, interrogation for sequence variants, gene copy number	Prior authorization is required.	
	amplifications and gene rearrangements		
	Oncology (solid organ), DNA, comprehensive genomic profiling, 257 genes, interrogation		
0244U	for single-nucleotide variants, insertions/deletions, copy number alterations, gene	Prior authorization is required.	
	rearrangements, tumor-mutational burden and microsatellite instability, utilizing formalin-		
	fixed paraffin-embedded tumor tissue Oncology (thyroid), mutation analysis of 10 genes and 37 RNA fusions and expression of 4		
0245U	mRNA markers using next-generation sequencing, fine needle aspirate, report includes	Prior authorization is required.	
02450	associated risk of malignancy expressed as a percentage	ritor autionzation srequired.	
	Red blood cell antigen typing, DNA, genotyping of at least 16 blood groups with phenotype		
0246U	prediction of at least 51 red blood cell antigens	Prior authorization is required.	
	Oncology (solid organ neoplasm), targeted genomic sequence DNA analysis of 505 genes,		
035011	interrogation for somatic alterations (SNVs [single nucleotide variant], small insertions and	Deine station is serviced	
0250U	deletions, one amplification and four translocations), microsatellite instability and tumor-	Prior authorization is required.	
	mutation burden		
	Fetal aneuploidy short tandem-repeat comparative analysis, fetal DNA from products of		
0252U	conception, reported as normal (euploidy), monosomy, trisomy, or partial	Prior authorization is required.	
	deletion/duplication, mosaicism and segmental aneuploidy		
	Reproductive medicine (endometrial receptivity analysis), RNA gene expression profile, 238		
0253U	genes by next-generation sequencing, endometrial tissue, predictive algorithm reported as	Prior authorization is required.	
	endometrial window of implantation (eg, pre-receptive, receptive, post-receptive)		
	Reproductive medicine (preimplantation genetic assessment), analysis of 24 chromosomes		
0254U	using embryonic DNA genomic sequence analysis for aneuploidy and a mitochondrial DNA	Prior authorization is required.	
	score in euploid embryos, results reported as normal (euploidy), monosomy, trisomy, or		
	partial deletion/duplication, mosaicism and segmental aneuploidy, per embryo tested		
	Autoimmune (psoriasis), mRNA, next-generation sequencing, gene expression profiling of		
0258U	50-100 genes, skin-surface collection using adhesive patch, algorithm reported as	Prior authorization is required.	
1		Phot authorization is required.	
	likelihood of response to psoriasis biologics	Phol authorization is required.	
	Rare diseases (constitutional/heritable disorders), identification of copy number variations,		
0260U	Rare diseases (constitutional/heritable disorders), identification of copy number variations, inversions, insertions, translocations and other structural variants by optical genome	Prior authorization is required.	
0260U	Rare diseases (constitutional/heritable disorders), identification of copy number variations, inversions, insertions, translocations and other structural variants by optical genome mapping		
	Rare diseases (constitutional/heritable disorders), identification of copy number variations, inversions, insertions, translocations and other structural variants by optical genome mapping Oncology (solid tumor), gene expression profiling by real-time RT-PCR of 7 gene pathways	Prior authorization is required.	
0260U 0262U	Rare diseases (constitutional/heritable disorders), identification of copy number variations, inversions, insertions, translocations and other structural variants by optical genome mapping 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),		
	Rare diseases (constitutional/heritable disorders), identification of copy number variations, inversions, insertions, translocations and other structural variants by optical genome mapping Oncology (solid tumor), gene expression profiling by real-time RT-PCR of 7 gene pathways (ER, AR, PI 3K, MAPK, IHI, TGFB, Notch), formalin-fixed paraffin-embedded (FFPE), algorithm reported as gene pathway activity score	Prior authorization is required.	
0262U	Rare diseases (constitutional/heritable disorders), identification of copy number variations, inversions, insections, translocations and other structural variants by optical genome mapping Oncology (solid tumor), gene expression profiling by real-time RT-PCR of 7 gene pathways (ER, AR, PJ SK, MAPK, HH, TGFB, Notch), formalin-fixed paraffin-embedded (FFPE), algorithm reported as gene pathway activity score Rare diseases (constitutional/heritable disorders), identification of copy number variations,	Prior authorization is required. Prior authorization is required.	
	Rare diseases (constitutional/heritable disorders), identification of copy number variations, inversions, insertions, translocations and other structural variants by optical genome mapping 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 Rare diseases (constitutional/heritable disorders), identification of copy number variations, inversions, insertions, translocations and other structural variants by optical genome	Prior authorization is required.	
0262U	Rare diseases (constitutional/heritable disorders), identification of copy number variations, inversions, insertions, translocations and other structural variants by optical genome mapping 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 Rare diseases (constitutional/heritable disorders), identification of copy number variations, inversions, insertions, translocations and other structural variants by optical genome mapping	Prior authorization is required. Prior authorization is required.	
0262U 0264U	Rare diseases (constitutional/heritable disorders), identification of copy number variations, inversions, insections, translocations and other structural variants by optical genome mapping Oncology (solid tumor), gene expression profiling by real-time RT-PCR of 7 gene pathways (ER, AR, P13K, MAPK, HH, TGFB, Notch), formalin-fixed paraffin-embedded (FFPE), algorithm reported as gene pathway activity score Rare diseases (constitutional/heritable disorders), identification of copy number variations, inversions, insertions, translocations and other structural variants by optical genome mapping Rare constitutional and other heritable disorders, whole genome and mitochondrial DNA	Prior authorization is required. Prior authorization is required. Prior authorization is required.	
0262U	Rare diseases (constitutional/heritable disorders), identification of copy number variations, inversions, insertions, translocations and other structural variants by optical genome mapping 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 Rare diseases (constitutional/heritable disorders), identification of copy number variations, inversions, insertions, translocations and other structural variants by optical genome mapping Rare constitutional and other heritable disorders, whole genome and mitochondrial DNA sequence analysis, blood, frozen and formalin-fixed paraffin-embedded (FFPE) tissue,	Prior authorization is required. Prior authorization is required.	
0262U 0264U	Rare diseases (constitutional/heritable disorders), identification of copy number variations, inversions, insections, translocations and other structural variants by optical genome mapping Oncology (solid tumor), gene expression profiling by real-time RT-PCR of 7 gene pathways (ER, AR, P13K, MAPK, HH, TGFB, Notch), formalin-fixed paraffin-embedded (FFPE), algorithm reported as gene pathway activity score Rare diseases (constitutional/heritable disorders), identification of copy number variations, inversions, insertions, translocations and other structural variants by optical genome mapping Rare constitutional and other heritable disorders, whole genome and mitochondrial DNA	Prior authorization is required. Prior authorization is required. Prior authorization is required.	
0262U 0264U	Rare diseases (constitutional/heritable disorders), identification of copy number variations, inversions, insertions, translocations and other structural variants by optical genome mapping 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 Rare diseases (constitutional/heritable disorders), identification of copy number variations, inversions, insertions, translocations and other structural variants by optical genome mapping 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	Prior authorization is required. Prior authorization is required. Prior authorization is required.	
0262U 0264U 0265U	Rare diseases (constitutional/heritable disorders), identification of copy number variations, inversions, insections, translocations and other structural variants by optical genome mapping Oncology (solid tumor), gene expression profiling by real-time RT-PCR of 7 gene pathways (RE, AR, PI3K, MAPK, HH, TGFB, Notch), formalin-fixed paraffin-embedded (FFPE), algorithm reported as gene pathway activity score Rare diseases (constitutional/heritable disorders), identification of copy number variations, inversions, insertions, translocations and other structural variants by optical genome mapping Rare constitutional and other heritable disorders, whole genome and mitochondrial DNA sequence analysis, blood, frozen and formalin-fixed paraffin-embedded (FFPE) tissue, saliva, buccal swabs or cell lines, identification of single nucleotide and copy number variants	Prior authorization is required. Prior authorization is required. Prior authorization is required. Prior authorization is required.	
0262U 0264U	Rare diseases (constitutional/heritable disorders), identification of copy number variations, inversions, insertions, translocations and other structural variants by optical genome mapping 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 Rare diseases (constitutional/heritable disorders), identification of copy number variations, inversions, insertions, translocations and other structural variants by optical genome mapping Rare constitutional/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 variatis Unexplained constitutional or other heritable disorders or syndromes, tissue-specific gene	Prior authorization is required. Prior authorization is required. Prior authorization is required.	
0262U 0264U 0265U	Rare diseases (constitutional/heritable disorders), identification of copy number variations, inversions, insections, translocations and other structural variants by optical genome mapping 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 Rare diseases (constitutional/heritable disorders), identification of copy number variations, inversions, insertions, translocations and other structural variants by optical genome mapping Rare constitutional/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 Unexplained constitutional or other heritable disorders or syndromes, tissue-specific gene expression by whole-transcriptome and next-generation sequencing, blood, formalin-fixed paraffin-embedded (FFPE) tissue or fresh frozen tissue, reported as presence or absence of splicing or expression changes	Prior authorization is required. Prior authorization is required. Prior authorization is required. Prior authorization is required.	
0262U 0264U 0265U 0266U	Rare diseases (constitutional/heritable disorders), identification of copy number variations, inversions, insections, translocations and other structural variants by optical genome mapping Oncology (solid tumon), gene expression profiling by real-time RT-PCR of 7 gene pathways (ER, AR, PI3K, MAPK, HH, TGFB, Notch), formalin-fixed parafine-mebedded (FFPE), algorithm reported as gene pathway activity score Rare diseases (constitutional/heritable disorders), identification of copy number variations, inversions, insertions, translocations and other structural variants by optical genome mapping 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 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 Rare constitutional and ther heritable disorders, identification of copy number variations,	Prior authorization is required.	
0262U 0264U 0265U	Rare diseases (constitutional/heritable disorders), identification of copy number variations, inversions, insections, translocations and other structural variants by optical genome mapping 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 Rare diseases (constitutional/heritable disorders), identification of copy number variations, inversions, insections, translocations and other structural variants by optical genome mapping 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 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 of fresh frozen tissue, reported as presence or absence of splicing or expression changes Rare constitutional and other heritable disorders identification of copy number variations, inversions, insertions, translocations and other structural variants by optical genome	Prior authorization is required. Prior authorization is required. Prior authorization is required. Prior authorization is required.	
0262U 0264U 0265U 0266U	Rare diseases (constitutional/heritable disorders), identification of copy number variations, inversions, insections, translocations and other structural variants by optical genome mapping 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 Rare diseases (constitutional/heritable disorders), identification of copy number variations, inversions, insertions, translocations and other structural variants by optical genome mapping 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 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 Rare constitutional and other heritable disorders, identification of copy number variations, inversions, insertions, translocations and other structural variants by optical genome mapping and whole genome sequencing.	Prior authorization is required.	
0262U 0264U 0265U 0266U	Rare diseases (constitutional/heritable disorders), identification of copy number variations, inversions, insections, translocations and other structural variants by optical genome mapping Oncology (solid tumor), gene expression profiling by real-time RT-PCR of 7 gene pathways (ER, AR, PI3K, MAPK, HH, TGFB, Notch), formalin-fixed paraffine-mbedded (FFPE), algorithm reported as gene pathway activity score Rare diseases (constitutional/heritable disorders), identification of copy number variations, inversions, insections, translocations and other structural variants by optical genome mapping 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 Unexplained constitutional or other heritable disorders or syndromes, tissue-specific gene paraffin-embedded (FFPE) tissue or fresh frozen tissue, reported as presence or absence of splicing or expression changes Rare constitutional and ther heritable disorders, identification of copy number variations, inversions, insertions, translocations and other structural variants by optical genome mapping methods there heritable disorders or syndromes, tissue-specific gene paraffin-embedded (FFPE) tissue or fresh frozen tissue, reported as presence or absence of splicing or expression changes 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 Hematology (atypical hemolytic uremic syndrome [AHUS]), genomic sequence analysis of	Prior authorization is required.	
0262U 0264U 0265U 0266U 0266U 0267U 0268U	Rare diseases (constitutional/heritable disorders), identification of copy number variations, inversions, insections, translocations and other structural variants by optical genome mapping 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 Rare diseases (constitutional/heritable disorders), identification of copy number variations, inversions, insections, translocations and other structural variants by optical genome mapping 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 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 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 Hematology (atypical hemolytic uremic syndrome [aHUS]), genomic sequence analysis of 15 genes, blood, buccal swab, or aminotic fluid	Prior authorization is required. Prior authorization is required.	
0262U 0264U 0265U 0266U 0266U	Rare diseases (constitutional/heritable disorders), identification of copy number variations, inversions, insections, translocations and other structural variants by optical genome mapping Oncology (solid tumor), gene expression profiling by real-time RT-PCR of 7 gene pathways (ER, AR, PI3K, MAPK, HH, TGFB, Notch), formalin-fixed paraffine-mbedded (FFPE), algorithm reported as gene pathway activity score Rare diseases (constitutional/heritable disorders), identification of copy number variations, inversions, insections, translocations and other structural variants by optical genome mapping 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 Unexplained constitutional or other heritable disorders or syndromes, tissue-specific gene paraffin-embedded (FFPE) tissue or fresh frozen tissue, reported as presence or absence of splicing or expression changes Rare constitutional and ther heritable disorders, identification of copy number variations, inversions, insertions, translocations and other structural variants by optical genome mapping methods there heritable disorders or syndromes, tissue-specific gene paraffin-embedded (FFPE) tissue or fresh frozen tissue, reported as presence or absence of splicing or expression changes 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 Hematology (atypical hemolytic uremic syndrome [AHUS]), genomic sequence analysis of	Prior authorization is required. Prior authorization is required.	

	Hematology (congenital coagulation disorders), genomic sequence analysis of 20 genes,		
0270U	blood, buccal swab, or amniotic fluid	Prior authorization is required.	
0271U	Hematology (congenital neutropenia), genomic sequence analysis of 23 genes, blood, buccal swab, or amniotic fluid	Prior authorization is required.	
0272U	Hematology (genetic bleeding disorders), genomic sequence analysis of 51 genes, blood, buccal swab, or amniotic fluid, comprehensive	Prior authorization is required.	
0273U	Hematology (genetic hyperfibrinolysis, delayed bleeding), analysis of 9 genes (F13A1, F13B, FGA, FGB, FGG, SERPINA1, SERPINE1, SERPINE2 by next-generation sequencing and PLAU by array comparative genomic hybridization), blood, buccal swab, or amniotic fluid	Prior authorization is required.	
0274T	Percutaneous laminotomy/laminectomy (interlaminar approach) for decompression of neural elements, (with or without ligamentous resection, discectomy, facetectomy and/or foraminotomy), any method, under indirect image guidance (e.g., fluoroscopic, CT), single or multiple levels, unilateral or bilateral; cervical or thoracic	Prior authorization is managed by EviCore.	Prior authorization is managed b EviCore.
0274U	Hematology (genetic platelet disorders), genomic sequence analysis of 43 genes, blood,	Prior authorization is required.	
0275T	buccal swab, or amniotic fluid Percutaneous laminotomy/laminectomy (interfaminar approach) for decompression of neural elements, (with or without ligamentous resection, discectomy, facetectomy and/or foraminotomy), any method, under indirect image guidance (e.g., fluoroscopic, CT), single or multiple levels, unilateral or bilateral; lumbar	Prior authorization is managed by EviCore.	Prior authorization is managed b EviCore.
0276U	Hematology (inherited thrombocytopenia), genomic sequence analysis of 42 genes, blood, buccal swab, or anniotic fluid	Prior authorization is required.	
0277U	Hematology (genetic platelet function disorder), genomic sequence analysis of 31 genes, blood, buccal swab, or amniotic fluid	Prior authorization is required.	
0278U	Hematology (genetic thrombosis), genomic sequence analysis of 12 genes, blood, buccal swab, or amnitic fluid	Prior authorization is required.	
0282U	Red blood cell antigen typing, DNA, genotyping of 12 blood group system genes to predict 44 red blood cell antigen phenotypes	Prior authorization is required.	
0285U	Oncology, response to radiation, cell-free DNA, quantitative branched chain DNA amplification, plasma, reported as a radiation toxicity score	Prior authorization is required.	
0286U	CEP72 (centrosomal protein, 72-KDa), NUDT15 (nudix hydrolase 15) and TPMT (thiopurine S-methyltransferase) (eg, drug metabolism) gene analysis, common variants	Prior authorization is required.	
0287U	Oncology (thyroid), DNA and mRNA, next-generation sequencing analysis of 112 genes, fine needle aspirate or formalin-fixed paraffin-embedded (FFPE) tissue, algorithmic prediction of cancer recurrence, reported as a categorical risk result (low, intermediate, high)	Prior authorization is required.	
0288U	Oncology (lung), mRNA, quantitative PCR analysis of 11 genes (BAG1, BRCA1, CDC6, CDK2AP1, ER8B3, FUT3, IL11, LCK, RND3, SH3BGR, WNT3A) and 3 reference genes (ESD, TBP, YAP1), formalin-fixed paraffin-embedded (FFFB) tumor tissue, algorithmic interpretation reported as a recurrence risk score	Prior authorization is required.	
0289U	Neurology (Alzheimer disease), mRNA, gene expression profiling by RNA sequencing of 24 genes, whole blood, algorithm reported as predictive risk score	Prior authorization is required.	
0290U	Pain management, mRNA, gene expression profiling by RNA sequencing of 36 genes, whole blood, algorithm reported as predictive risk score	Prior authorization is required.	
0291U	Psychiatry (mood disorders), mRNA, gene expression profiling by RNA sequencing of 144 genes, whole blood, algorithm reported as predictive risk score	Prior authorization is required.	
0292U	Psychiatry (stress disorders), mRNA, gene expression profiling by RNA sequencing of 72 genes, whole blood, algorithm reported as predictive risk score	Prior authorization is required.	
0293U	Psychiatry (suicidal ideation), mRNA, gene expression profiling by RNA sequencing of 54 genes, whole blood, algorithm reported as predictive risk score	Prior authorization is required.	
0294U	Longevity and mortality risk, mRNA, gene expression profiling by RNA sequencing of 18 genes, whole blood, algorithm reported as predictive risk score	Prior authorization is required.	
0296U	Oncology (oral and/or orophary geal cancer), gene expression profiling by RNA sequencing of at least 20 molecular features (eg, human and/or microbial mRNA), saliva, algorithm reported as positive or negative for signature associated with malignancy	Prior authorization is required.	
0297U	Oncology (pan tumor), whole genome sequencing of paired malignant and normal DNA specimens, fresh or formalin-fixed paraffin-embedded (FFPE) tissue, blood or bone marrow, comparative sequence analyses and variant identification	Prior authorization is required.	
0298U	Oncology (pan tumor), whole transcriptome sequencing of paired malignant and normal RNA specimens, fresh or formalin-fixed paraffin-embedded (FFPE) tissue, blood or bone marrow, comparative sequence analyses and expression level and chimeric transcript identification	Prior authorization is required.	
0299U	Oncology (pan tumor), whole genome optical genome mapping of paired malignant and normal DNA specimens, fresh frozen tissue, blood, or bone marrow, comparative structural variant identification	Prior authorization is required.	
0300U	Oncology (pan tumor), whole genome sequencing and optical genome mapping of paired malignant and normal DNA specimens, fresh tissue, blood, or bone marrow, comparative sequence analyses and variant identification	Prior authorization is required.	
0301U	Infectious agent detection by nucleic acid (DNA or RNA), Bartonella henselae and Bartonella quintana, droplet digital PCR (ddPCR);	Prior authorization is required.	

	Infectious agent detection by nucleic acid (DNA or RNA), Bartonella henselae and			
0302U	Bartonella quintana, droplet digital PCR (ddPCR); following liquid enrichment	Prior authorization is required.		
	Vagus nerve blocking therapy (morbid obesity); laparoscopic implantation of			
0312T	neurostimulator electrode array, anterior and posterior vagal trunks adjacent to	Prior authorization is required.		
03121	esophagogastric junction (EGJ), with implantation of pulse generator, includes	Filor autionzation is required.		
	programming			
	Vagus nerve blocking therapy (morbid obesity); laparoscopic revision or replacement of			
0313T	vagal trunk neurostimulator electrode array, including connection to existing pulse	Prior authorization is required.		
	generator			
	Oncology (pancreas), DNA and mRNA next-generation sequencing analysis of 74 genes			
0313U	and analysis of CEA (CEACAM5) gene expression, pancreatic cyst fluid, algorithm reported	Prior authorization is required.		
	as a categorical result (ie, negative, low probability of neoplasia or positive, high probability of neoplasia)			
	Vagus nerve blocking therapy (morbid obesity); laparoscopic removal of vagal trunk			
0314T	neurostimulator electrode array and pulse generator	Prior authorization is required.		
	Oncology (cutaneous melanoma), mRNA gene expression profiling by RT-PCR of 35 genes			
0314U	(32 content and 3 housekeeping), utilizing formalin-fixed paraffin-embedded (FFPE) tissue,	Prior authorization is required.		
	algorithm reported as a categorical result (ie, benign, intermediate, malignant)			
0315T	Vagus nerve blocking therapy (morbid obesity); removal of pulse generator	Prior authorization is required.		
	Oncology (cutaneous squamous cell carcinoma), mRNA gene expression profiling by RT-			
0315U	PCR of 40 genes (34 content and 6 housekeeping), utilizing formalin-fixed paraffin-	Prior authorization is required.		
00100	embedded (FFPE) tissue, algorithm reported as a categorical risk result (ie, Class 1, Class	no actionation brequirea.		
	2A, Class 2B)			
0316T	Vagus nerve blocking therapy (morbid obesity); replacement of pulse generator	Prior authorization is required.		
0317T	Vagus nerve blocking therapy (morbid obesity); neurostimulator pulse generator electronic	Prior authorization is required.		
	analysis, includes reprogramming when performed			Prior authorization is managed by
0331T	Myocardial sympathetic innervation imaging, planar qualitative and quantitative assessment;	Prior authorization is managed by EviCore.		EviCore.
				Prior authorization is managed by
0332T	Myocardial sympathetic innervation imaging, planar qualitative and quantitative assessment; with tomographic SPECT	Prior authorization is managed by EviCore.		EviCore.
	Oncology (pan-tumor), genetic profiling of 8 DNA-regulatory (epigenetic) markers by			EVICOIE.
0332U	quantitative polymerase chain reaction (qPCR), whole blood, reported as a high or low	Prior authorization is required.		
00020	probability of responding to immune checkpoint-inhibitor therapy			
	Oncology (liver), surveillance for hepatocellular carcinoma (HCC) in high-risk patients,			
00000	analysis of methylation patterns on circulating cell-free DNA (cfDNA) plus measurement of			
0333U	serum of AFP/AFP-L3 and oncoprotein des-gamma-carboxy-prothrombin (DCP), algorithm	Prior authorization is required.		
	reported as normal or abnormal result			
	Rare diseases (constitutional/heritable disorders), whole genome sequence analysis,			
	including small sequence changes, copy number variants, deletions, duplications, mobile			
0335U	element insertions, uniparental disomy (UPD), inversions, aneuploidy, mitochondrial	Prior authorization is required.		
00000	genome sequence analysis with heteroplasmy and large deletions, short tandem repeat			
	(STR) gene expansions, fetal sample, identification and categorization of genetic variants			
	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			
0336U	genome sequence analysis with heteroplasmy and large deletions, short tandem repeat	Prior authorization is required.		
	(STR) gene expansions, blood or saliva, identification and categorization of genetic variants,			
	each comparator genome (eg, parent)			
	Oncology (pan-cancer), analysis of minimal residual disease (MRD) from plasma, with			
024011	assays personalized to each patient based on prior next-generation sequencing of the	Deine with a visation is serviced		
0340U	patient's tumor and germline DNA, reported as absence or presence of MRD, with disease-	Prior authorization is required.		
	burden correlation, if appropriate			
	Fetal aneuploidy DNA sequencing comparative analysis, fetal DNA from products of			
0341U	conception, reported as normal (euploidy), monosomy, trisomy, or partial	Prior authorization is required.		
	deletion/duplication, mosaicism and segmental aneuploid			
	Collagen cross-linking of cornea, including removal of the corneal epithelium, when	Prior authorization is required.	HHO-DE-MP-1099 Corneal Surgery to Correct Refractive Errors,	
0402T	performed and intraoperative pachymetry, when performed	Reference policies for additional information.	Phototherapeutic Keratectomy and Corneal Collagen Cross-	
			Linking Surgery	
0439T	Myocardial contrast perfusion echocardiography, at rest or with stress, for assessment of	Prior authorization is managed by EviCore.		Prior authorization is managed by
04391	myocardial ischemia or viability (List separately in addition to code for primary procedure)	Prior autionization is managed by EVICORE.		EviCore.
	Insertion of wireless cardiac stimulator for left ventricular pacing, including device			Prior authorization is managed by
0515T	interrogation and programming and imaging supervision and interpretation, when	Prior authorization is managed by EviCore.		EviCore.
	performed; complete system (includes electrode and generator [transmitter and battery])			
	Insertion of wireless cardiac stimulator for left ventricular pacing, including device			Deisserthesiseti i ii
0516T	interrogation and programming and imaging supervision and interpretation, when	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
	performed; electrode only			Evicore.
	Insertion of wireless cardiac stimulator for left ventricular pacing, including device			Prior authorization is managed by
0517T		Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.

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

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

0866T	Quantitative magnetic resonance image (MRI) analysis of the brain with comparison to prior magnetic resonance (MR) study (ies), including lesion detection, characterization, and quantification, with brain volume(s) quantification and/or severity score, when performed, data preparation and transmission, interpretation and report, obtained with diagnostic MRI examination of the brain (List separately in addition to code for primary procedure)	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
A0090	Nonemergency transportation, per mile - vehicle provided by individual (family member, self, neighbor) with vested interest	Reference policies for additional information. the DMMA Provider Portal https://medicaid.dhss.delaware.gov		
A0100	Nonemergency transportation; taxi	Reference policies for additional information. the DMMA Provider Portal. https://medicaid.dhss.delaware.gov		
A0110	Nonemergency transportation and bus, intra- or interstate carrier	Reference policies for additional information. the DMMA Provider Portal. https://medicaid.dhss.delaware.gov		
A0120	Nonemergency transportation: mini-bus, mountain area transports, or other transportation systems	Reference policies for additional information. the DMMA Provider Portal. https://medicaid.dhss.delaware.gov		
A0130	Nonemergency transportation: wheelchair van	Reference policies for additional information. the DMMA Provider Portal. https://medicaid.dhss.delaware.gov		
A0160	Nonemergency transportation: per mile - caseworker or social worker	Reference policies for additional information. the DMMA Provider Portal. https://medicaid.dhss.delaware.gov		
A0426	Ambulance service, advanced life support, nonemergency transport, level 1 (ALS 1)	Reference policies for additional information. the DMMA Provider Portal. https://medicaid.dhss.delaware.gov		
A0428	Ambulance service, basic life support, nonemergency transport, (BLS)	Reference policies for additional information. the DMMA Provider Portal. https://medicaid.dhss.delaware.gov		
A4100	Skin substitute, fda cleared as a device, not otherwise specified	Prior authorization is required for billed charges greater than \$500.		1
A4206	SYRINGE W/NEEDLE STERIL 1 CC/< EACH	Prior authorization is required when the billed charges are greater than \$500.		1
A4207	SYRINGE W/NEEDLE STERILE 2 CC EACH	Prior authorization is required when the billed charges are greater than \$500.		1
A4208	SYRINGE W/NEEDLE STERILE 2 CC EACH	Prior authorization is required when the billed charges are greater than \$500.		1
A4209	SYRINGE W/NEEDLE STERILE 5 CC/>EA	Prior authorization is required when the billed charges are greater than \$500.		
A4210	NEEDLE-FREE INJECTION DEVICE EACH	Prior authorization is required when the billed charges are greater than \$500.		
A4210 A4211	SUPPLIES SELF-ADMINED INJECTIONS	Prior authorization is required when the billed charges are greater than \$500.		
A4211 A4212	NONCORING NEEDLE/STYLET W/WO CATH			
		Prior authorization is required when the billed charges are greater than \$500.		
A4213 A4215	SYRINGE STERILE 20 CC/GREATER EACH NEEDLE STERILE ANY SIZE EACH	Prior authorization is required when the billed charges are greater than \$500.		
		Prior authorization is required when the billed charges are greater than \$500.		
A4216 A4217	STERL H2O SALINE & OR DXT DIL 10 ML	Prior authorization is required when the billed charges are greater than \$500.		
	STERILE WATER/SALINE 500 ML	Prior authorization is required when the billed charges are greater than \$500.		
A4218	STERL SALINE/WATR METRD DOSE 10 ML	Prior authorization is required when the billed charges are greater than \$500.		
A4220	REFILL KIT IMPLANTABLE INFUS PUMP	Prior authorization is required when the billed charges are greater than \$500.		
A4221	Supplies for maintenance of noninsulin drug infusion catheter, per week (list drugs separately)	Prior authorization is required for billed charges greater than \$500. Reference policies for additional information.	HHO-DE-MP-1134 Portable External Infusion Pump	
A4222	Infusion supplies for external drug infusion pump, per cassette or bag (list drugs separately)	Prior authorization is required for billed charges greater than \$500. Reference policies for additional information.	HHO-DE-MP-1134 Portable External Infusion Pump	
A4223	INFUS SPL NO EXT INFUS PUMP CAS/BAG	Prior authorization is required when the billed charges are greater than \$500.		
A4224	SPL MAINT INSULIN INFUS CATH PER WK	Prior authorization is required when the billed charges are greater than \$500.		
A4225	SPL EXT INS INF PMP SYR T CART ST E	Prior authorization is required when the billed charges are greater than \$500.		
A4226	S MNT INS IP DR ADJ TX CNT G SNS PW	Prior authorization is required when the billed charges are greater than \$500.		
A4230	INFUS SET EXT INSULIN PUMP NONNDLE	Prior authorization is required when the billed charges are greater than \$500.		
A4231	INFUS SET EXT INSULIN PUMP NEEDLE	Prior authorization is required when the billed charges are greater than \$500.		
A4232	SYRINGE NDLE EXT INSULIN PUMP STERL	Prior authorization is required when the billed charges are greater than \$500.		
A4233	REPL BATT ALK NOT J CELL HOM BG MON	Prior authorization is required when the billed charges are greater than \$500.		
A4234	REPL BATT ALK J CELL HOM BG MON	Prior authorization is required when the billed charges are greater than \$500.		
A4235	REPL BATT LITHIUM HOM BG MON OWN PT	Prior authorization is required when the billed charges are greater than \$500.		1
A4236	REPL BATT SILVER OXIDE HOM BG MON	Prior authorization is required when the billed charges are greater than \$500.		1
A4238	SPL ALW ADJ CGM S & ACC 1 M S=1 U S	Prior authorization is required when the billed charges are greater than \$500.		1
A4239	Supply allowance for non-adjunctive, non-implanted continuous glucose monitor (cgm), includes all supplies and accessories, 1 month supply = 1 unit of service	Prior authorization is required when the billed charges are greater than \$500.		
A4244	ALCOHOL OR PEROXIDE PER PINT	Prior authorization is required when the billed charges are greater than \$500.		
A4245	ALCOHOL WIPES PER BOX	Prior authorization is required for billed charges greater than \$500. Reference policies for additional information.	HHO-DE-MP-1246 Home Dialysis Equipment and Supplies	
A4246	BETADINE/PHISOHEX SOLUTION PER PINT	Prior authorization is required when the billed charges are greater than \$500.		1
A4246 A4247	BETADINE/PHISOHEX SOLUTION PER PINI BETADINE/IODINE SWABS/WIPES PER BOX	Prior authorization is required when the billed charges are greater than \$500.		+
A4247 A4248	BE I ADINE/IODINE SWABS/WIPES PER BOX CHLORHEXIDINE CONTAINING ANTISEPTIC	Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500.		
A4248 A4250	URINE TEST/REAGENT STRIPS/TABLETS	Prior authorization is required when the billed charges are greater than \$500.		+
A4250 A4252	URINE TEST/REAGENT STRIPS/TABLETS BLOOD KETONE TEST/REAGENT STRIP EA			
		Prior authorization is required when the billed charges are greater than \$500.		
A4253	BLD GLU TST/REAGT STRIPS HOM MON-50	Prior authorization is required when the billed charges are greater than \$500.		+
A4255	PLATFORMS HOM BLD GLU MON 50-BOX	Prior authorization is required when the billed charges are greater than \$500.		
A4256	NORMALLOW&HI CALIBRATOR SOL/CHIPS	Prior authorization is required when the billed charges are greater than \$500.		
A4257	REPL LENS SHIELD CARTRIDGE LASR SKN	Prior authorization is required when the billed charges are greater than \$500.		
A4258	SPRING-POWERED DEVICE LANCET EACH	Prior authorization is required when the billed charges are greater than \$500.		
A4259 A4262	LANCETS PER BOX OF 100 TEMP ABSORB LAC DUCT IMPLANT EA	Prior authorization is required when the billed charges are greater than \$500.		l
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MAXITDescription of the Maxima and Security of the	A4285	POLYCARBATE BOTTLE BREAST PUMP REPL	Prior authorization is required when the billed charges are greater than \$500.		
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	A4373 A4375	OST SKN BARR W/FLNGE BUILT-IN CONVX OST POUCH DRNABLE W/FCEPLAT PLST EA	Prior authorization is required when the billed charges are greater than \$500.		
A4378 OST POUCH DRAINABLE FCEPLAT RUBR EA Prior authorization is required when the billed charges are greater than \$500.	A4373 A4375 A4376	OST SKN BARR W/FLNGE BUILT-IN CONVX OST POUCH DRNABLE W/FCEPLAT PLST EA OST POUCH DRNABLE W/FCEPLAT RUBR EA	Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500.		
	A4373 A4375 A4376 A4377	OST SKN BARR W/FLNGE BUILT-IN CONVX OST POUCH DRNABLE W/FCEPLAT PLST EA OST POUCH DRNABLE W/FCEPLAT RUBR EA OST POUCH DRNABLE FCEPLAT PLSTC EA	Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500.		

A4379	OST POUCH URIN W/FCEPLAT PLSTC EA	Prior authorization is required when the billed charges are greater than \$500.	
A4380	OST POUCH URIN W/FCEPLAT RUBR EA	Prior authorization is required when the billed charges are greater than \$500.	
A4381	OST POUCH URIN USE FCEPLAT PLSTC EA	Prior authorization is required when the billed charges are greater than \$500.	
A4382	OST POUCH URIN FCEPLAT HVY PLSTC EA	Prior authorization is required when the billed charges are greater than \$500.	
A4383	OST POUCH URIN USE FCEPLAT RUBR EA	Prior authorization is required when the billed charges are greater than \$500.	
A4384	OST FCEPLAT EQUVALNT SILCON RING EA	Prior authorization is required when the billed charges are greater than \$500.	
A4385	OST SKN BARRIER 4X4 EXT W/O CONVXTY	Prior authorization is required when the billed charges are greater than \$500.	
A4387	OST POUCH CLOS BARR BUILT-IN CONVX	Prior authorization is required when the billed charges are greater than \$500.	
A4388	OST POUCH DRNABL W/EXT WEAR BARR EA	Prior authorization is required when the billed charges are greater than \$500.	
A4388	OST POUCH DRNBL BARR BUILT-IN CONVX	Prior authorization is required when the billed charges are greater than \$500.	
A4389 A4390	OST POUCH DRNABLE EXT W/CONVXITY EA	Prior authorization is required when the billed charges are greater than \$500.	
A4391	OST POUCH URIN W/EXT WEAR BARR EA	Prior authorization is required when the billed charges are greater than \$500.	
A4392	OST POUCH URIN STD W/CONVXITY EA	Prior authorization is required when the billed charges are greater than \$500.	
A4393	OST POUCH URIN EXT W/CONVXITY EA	Prior authorization is required when the billed charges are greater than \$500.	
A4394	OSTOMY DEODORANT W/WO LUB PER FL OZ	Prior authorization is required when the billed charges are greater than \$500.	
A4395	OST DEODORANT OST POUCH SOLID-TAB	Prior authorization is required when the billed charges are greater than \$500.	
A4396	OSTOMY BELT W/PERISTOMAL HERN SUP	Prior authorization is required when the billed charges are greater than \$500.	
A4397	IRRIGATION SUPPLY; SLEEVE EACH	Prior authorization is required when the billed charges are greater than \$500.	
A4398	OSTOMY IRRIGATION SUPPLY; BAG EACH	Prior authorization is required when the billed charges are greater than \$500.	
A4399	OST IRRIG SPL; CONE/CATH W/WO BRUSH	Prior authorization is required when the billed charges are greater than \$500.	
A4400	OSTOMY IRRIGATION SET	Prior authorization is required when the billed charges are greater than \$500.	
A4402	LUBRICANT PER OUNCE	Prior authorization is required when the billed charges are greater than \$500.	
A4404	OSTOMY RING EACH	Prior authorization is required when the billed charges are greater than \$500.	
A4405	OST SKN BARRIER NONPECTIN PASTE-OZ	Prior authorization is required when the billed charges are greater than \$500.	
A4406	OST SKN BARRIER PECTIN PASTE-OZ	Prior authorization is required when the billed charges are greater than \$500.	
A4407	OST SKN BARRIER W/CONVXITY 4X4 IN/<	Prior authorization is required when the billed charges are greater than \$500.	
A4408	OST SKN BARRIER W/CONVXITY > 4X4 IN	Prior authorization is required when the billed charges are greater than \$500.	
A4409	OST SKN BARR EXT W/O CONVX 4X4 IN/<	Prior authorization is required when the billed charges are greater than \$500.	
A4410	OST SKN BARR EXT W/O CONVX >4X4 IN	Prior authorization is required when the billed charges are greater than \$500.	
A4410 A4411	OST SKN BARR SOLID 4X4/EQ W/CONVXTY	Prior authorization is required when the billed charges are greater than \$500.	
A4411 A4412	OST SNN BARR SOLID 4A4/EQ W/CONVATY OST POUCH DRNBL BARR FLNGE W/O FLTR	Prior authorization is required when the billed charges are greater than \$500.	
A4412 A4413	OST POUCH DRIVBL BARR FLIVGE W/O FETR		
A4413 A4414		Prior authorization is required when the billed charges are greater than \$500.	
,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	OST SKN BARRIER W/O CONVX 4X4 IN/<	Prior authorization is required when the billed charges are greater than \$500.	
A4415	OST SKN BARRIER W/O CONVX >4X4 IN	Prior authorization is required when the billed charges are greater than \$500.	
A4416	OST POUCH CLO BARR ATTCH W/FILTR EA	Prior authorization is required when the billed charges are greater than \$500.	
A4417	OST POUCH CLO BARR W/BLT-IN CONVXIT	Prior authorization is required when the billed charges are greater than \$500.	
A4418	OST POUCH CLOS; W/O BARR W/FILTR EA	Prior authorization is required when the billed charges are greater than \$500.	
A4419	OST POUCH CLOS; BARRIER W/NON-LOCK	Prior authorization is required when the billed charges are greater than \$500.	
A4420	OST POUCH CLO; USE BARR LOCK FLNG EA	Prior authorization is required when the billed charges are greater than \$500.	
A4421	Ostomy supply; miscellaneous	Prior authorization is required for billed charges greater than \$500.	
A4422	OST ABSORB MATL THICKN LQD STOML OP	Prior authorization is required when the billed charges are greater than \$500.	
A4423	OST POUCH CLOS; BARR W/LOCK FLNG EA	Prior authorization is required when the billed charges are greater than \$500.	
A4424	OST POUCH DRNBL BARR ATTCH FILTR EA	Prior authorization is required when the billed charges are greater than \$500.	
A4425	OST POUCH DRNBL; BARR NON-LOCK FLNG	Prior authorization is required when the billed charges are greater than \$500.	
A4426	OST POUCH DRNBL; BARR W/LOCK FLNG EA	Prior authorization is required when the billed charges are greater than \$500.	
A4427	OST POUCH DRN; BARR LOCK FLNG FLTR	Prior authorization is required when the billed charges are greater than \$500.	
A4428	OST POUCH URIN W/FAUCET TAP W/VALVE	Prior authorization is required when the billed charges are greater than \$500.	
A4429	OST POUCH URIN W/BLT-IN CONVX VALVE	Prior authorization is required when the billed charges are greater than \$500.	
A4430	OST POUCH URN BLT-IN CNVX FAUCT VLV	Prior authorization is required when the billed charges are greater than \$500.	
A4431	OST POUCH URIN;BARR FAUCT TAP VLV	Prior authorization is required when the billed charges are greater than \$500.	
A4432	OST POUCH URN;NO-LCK FLNG FAUCT VLV	Prior authorization is required when the billed charges are greater than \$500.	
A4432	OST POUCH URIN; BARR W/LOCK FLNG FA	Prior authorization is required when the billed charges are greater than \$500.	
A4435	OST POUCH URN; DAMK W/ COCK FLNG EA	Prior authorization is required when the billed charges are greater than \$500.	
A4434 A4435	OST POUCH DRN, LOCK PLING FAUCT VLV	Prior authorization is required when the billed charges are greater than \$500.	
A4435 A4436	IRRIGATION SUPPLY SLV REUSE PER MTH	Prior authorization is required when the billed charges are greater than \$500.	
A4436 A4437			
	IRRIGATION SUPPLY SLV DISP PER MNTH	Prior authorization is required when the billed charges are greater than \$500.	
A4450	TAPE NON-WATERPROOF 18 SQUARE IN	Prior authorization is required when the billed charges are greater than \$500.	
A4452	TAPE WATERPROOF PER 18 SQUARE IN	Prior authorization is required when the billed charges are greater than \$500.	
A4455	ADHESIVE REMOVER/SOLVENT PER OUNCE	Prior authorization is required when the billed charges are greater than \$500.	
A4456	ADHESIVE REMOVER WIPES ANY TYPE EA	Prior authorization is required when the billed charges are greater than \$500.	
A4457	Enema tube, with or without adapter, any type, replacement only, each	Prior authorization is required if more than 8 units are billed per day.	
A4458	Enema bag with tubing, reusable	Prior authorization is required if more than 8 units are billed per day.	
A4459	Manual purport and an analysis and the balloop and balloop and all appropriate	Prior authorization is required if more than 9 units are hilled nor day	
	Manual pump-operated enema system, includes balloon, catheter and all accessories,		
	reusable, any type	Prior authorization is required if more than 8 units are billed per day.	
A4461	reusable, any type SURG DRESSING HOLDR NON-REUSABLE EA	Prior authorization is required when the billed charges are greater than \$500.	
A4463	reusable, any type SURG DRESSING HOLDR NON-REUSABLE EA SURG DRESSING HOLDER REUSABLE EA	Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500.	
	reusable, any type SURG DRESSING HOLDR NON-REUSABLE EA	Prior authorization is required when the billed charges are greater than \$500.	

A4470	GRAVLEE JET WASHER	Prior authorization is required when the billed charges are greater than \$500.		
A4480	VABRA ASPIRATOR	Prior authorization is required when the billed charges are greater than \$500.		
A4481	TRACHEOSTOMA FLTR TYPE SZ EA	Prior authorization is required when the billed charges are greater than \$500.		
A4483	MOISTR EXCHGR DISPBL W/INVASV VENT	Prior authorization is required when the billed charges are greater than \$500.		
A4490	SURG STOCKING ABOVE KNEE LENGTH EA	Prior authorization is required when the billed charges are greater than \$500.		
A4495	SURGICAL STOCKING THIGH LENGTH EACH	Prior authorization is required when the billed charges are greater than \$500.		
A4500	SURG STOCKING BELOW KNEE LENGTH EA	Prior authorization is required when the billed charges are greater than \$500.		
A4510	SURGICAL STOCKING FULL-LENGTH EACH	Prior authorization is required when the billed charges are greater than \$500.		
A4520	INCONTINENCE GARMENT ANY TYPE EACH	Prior authorization is required when the billed charges are greater than \$500.		
A4550 A4553	SURGICAL TRAYS Nondisposable underpads, all sizes	Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required if more than 8 units are billed per day.		
A4553 A4554	Disposable underpads, all sizes	Prior authorization is required if more than 8 units are billed per day. Prior authorization is required if more than 8 units are billed per day.		
A4555	E/TRANSDUCR E-STIM U CA TX RPL ONLY	Prior authorization is required when the billed charges are greater than \$500.		
A4556	ELECTRODES PER PAIR	Prior authorization is required when the billed charges are greater than \$500.		
A4557	LEAD WIRES PER PAIR	Prior authorization is required when the billed charges are greater than \$500.		
A4558	CONDUCTVE GEL/PASTE USE W/ELEC DEVC	Prior authorization is required when the billed charges are greater than \$500.		
		Prior authorization is required for billed charges greater than \$500. Reference policies for		
A4559	Coupling gel or paste, for use with ultrasound device, per oz	additional information.	HHO-DE-MP-1251 Ultrasound Osteogenesis Stimulator	
A4561	PESSARY RUBBER ANY TYPE	Prior authorization is required when the billed charges are greater than \$500.		
A4562	PESSARY NON RUBBER ANY TYPE	Prior authorization is required when the billed charges are greater than \$500.		
A4563	RCTL CNTRL SYS VAG INSRT LT U ANY E	Prior authorization is required when the billed charges are greater than \$500.		
A4565	SLINGS	Prior authorization is required when the billed charges are greater than \$500.		
A4566	SHOULDR SLING/VEST ABD RSTRN PREFAB	Prior authorization is required when the billed charges are greater than \$500.		
A4570	SPLINTS	Prior authorization is required when the billed charges are greater than \$500.		
A4575	TOPICAL HYPRBR OXYGEN CHAMB DISPBL	Prior authorization is required when the billed charges are greater than \$500.		
A4580	CAST SUPPLIES	Prior authorization is required when the billed charges are greater than \$500.		
A4590	SPECIAL CASTING MATERIAL	Prior authorization is required when the billed charges are greater than \$500.		
A4595	Electrical stimulator supplies, 2 lead, per month, (e.g., TENS, NMES)	Prior authorization is required for billed charges greater than \$500. Reference policies for additional information.	HHO-DE-MP-1185 Functional Neuromuscular Electrical Stimulation and Other Electrical Stimulator	
A4596	CES SYS SUP & ACCESSORIES PER MONTH	Prior authorization is required when the billed charges are greater than \$500.		
A4600	SLEEVE INTERMITT LIMB COMP REPL EA	Prior authorization is required when the billed charges are greater than \$500.		
A4601	LIB RECHARG NONPROSTHETIC USE REPL	Prior authorization is required when the billed charges are greater than \$500.		
A4602	REPL BA EXT IP OWND PT LI 1.5 V EA	Prior authorization is required when the billed charges are greater than \$500.		
A4604	Tubing with integrated heating element for use with positive airway pressure device	Prior authorization is required for billed charges greater than \$500. Reference policies for additional information.	HHO-DE-MP-1063 Devices Used for the Treatment of Obstructive Sleep Apnea in Adults and HHO-DE-MP-1076 Respiratory Assist Devices	
A4605	TRACHEAL SUCTION CATH CLOS SYS EA	Prior authorization is required when the billed charges are greater than \$500.		
A4606	O2 PROBE W/OXIMETER DEVICE REPLCMT	Prior authorization is required for billed charges greater than \$500. Reference policies for additional information.	HHO-DE-MP-1072 Oxygen and HHO-DE-MP-1030 Home Oxygen Therapy	
A4608	TRANSTRACHEAL OXYGEN CATHETER EACH	Prior authorization is required for billed charges greater than \$500. Reference policies for additional information.	HHO-DE-MP-1072 Oxygen	
A4611	BATTRY HEVY DUTY; REPL PT-OWND VENT	Prior authorization is required when the billed charges are greater than \$500.		
A4611 A4612	BATTRY CABLES; REPL PT-OWNED VENT	Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500.		
A4612 A4613	BATTRY CABLES; REPL PT-OWNED VENT BATTRY CHARGER; REPL PT-OWNED VENT	Prior authorization is required when the billed charges are greater than \$500.		
A4613	PEAK EXPIRATORY FLW METER HAND HELD	Prior authorization is required when the billed charges are greater than \$500.		
A4615	CANNULA NASAL	Prior authorization is required when the once the grader than 5500. Prior authorization is required for billed charges greater than \$500. Reference policies for additional information.	HHO-DE-MP-1072 Oxygen	
A4616	TUBING PER FOOT	Prior authorization is required for billed charges greater than \$500. Reference policies for	HHO-DE-MP-1072 Oxygen	
A4617	MOUTHPIECE	additional information. Prior authorization is required for billed charges greater than \$500. Reference policies for	HHO-DE-MP-1072 Oxygen	
A4618	BREATHING CIRCUITS	additional information.		
A4618 A4619	BREATHING CIRCUITS FACE TENT	Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required for billed charges greater than \$500. Reference policies for	HHO-DE-MP-1072 Oxygen	
		additional information.		
A4620	VARIABLE CONCENTRATION MASK	Prior authorization is required for billed charges greater than \$500. Reference policies for	HHO-DF-MP-1072 Oxygen	
A4620		additional information.	HHO-DE-MP-1072 Oxygen	
A4623	TRACHEOSTOMY INNER CANNULA	additional information. Prior authorization is required when the billed charges are greater than \$500.	HHO-DE-MP-1072 Oxygen	
A4623 A4624	TRACHEOSTOMY INNER CANNULA TRACHEAL SUCTN CATH NOT CLOS SYS EA	additional information. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500.	HHO-DE-MP-1072 Oxygen	
A4623 A4624 A4625	TRACHEOSTOM Y INNER CANNULA TRACHEAL SUCTN CATH NOT CLOS SYS EA TRACHEOST CARE KIT NEW TRACHEOST	additional information. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500.	HHO-DE-MP-1072 Oxygen	
A4623 A4624 A4625 A4626	TRACHEOSTOMY INNER CANNULA TRACHEAL SUCTN CATH NOT CLOS SYS EA TRACHEOST CARE KIT NEW TRACHEOST TRACHEOSTOMY CLEANING BRUSH EACH	additional information. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500.	HHO-DE-MP-1072 Oxygen	
A4623 A4624 A4625 A4626 A4626 A4627	TRACHEOSTOMY INNER CANNULA TRACHEAL SUCTN CATH NOT CLOS SYS EA TRACHEOST CARE KIT NEW TRACHEOST TRACHEOSTOMY CLEANING BRUSH EACH SPACR BAG/RESRVOR METRD DOSE INHAL	additional information. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500.	HHO-DE-MP-1072 Oxygen	
A4623 A4624 A4625 A4626 A4626 A4627 A4628	TRACHEOSTOM Y INNER CANNULA TRACHEAL SUCTN CATH NOT CLOS SYS EA TRACHEOST CARE KIT NEW TRACHEOST TRACHEOSTOM Y LEANING BRUSH EACH SPACE RAG/RESRVOR NETRO DOSE INHAL OROPHARYINGEAL SUCTION CATHETER EACH	additional information. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500.	HHO-DE-MP-1072 Oxygen	
A4623 A4624 A4625 A4626 A4627 A4628 A4628 A4629	TRACHEOSTOM Y INNER CANNULA TRACHEAL SUCTN CATH NOT CLOS SYS EA TRACHEOST CARE KIT NEW TRACHEOST TRACHEOSTOMY CLEANING BRUSH EACH SPACR BAG/RESRVOR METRD DOSE INHAL OROPHARYNGEAL SUCTION CATHETRE RACH TRACHEOST CARE KIT EST TRACHEOST	additional information. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500.	HHO-DE-MP-1072 Oxygen	
A4623 A4624 A4625 A4626 A4627 A4628 A4629 A4630	TRACHEOSTOM Y INNER CANNULA TRACHEAL SUCTN CATH NOT CLOS SYS EA TRACHEOST CARE KIT NEW TRACHEOST TRACHEOSTOMY CLEANING BRUSH EACH SPACR BAG/RESRVOR METRD DOSE INHAL OROPHARYNGEAL SUCTION CATHETER EACH TRACHEOST CARE KIT EST TRACHEOST REPL BATTRY TRNSQ ELEC STIM OWND PT	additional information. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500.	HHO-DE-MP-1072 Oxygen	
A4623 A4624 A4625 A4626 A4627 A4628 A4629 A4630 A4630 A4633	TRACHEOSTOM Y INNER CANNULA TRACHEOST CARE KIT NEW TRACHEOST TRACHEOST CARE KIT NEW TRACHEOST TRACHEOSTOMY CLEANING BRUSH EACH SPACE RAG/RESRVOR METRD DOSE INNAL OROPHARYNGEAL SUCTION CATHETER EACH TRACHEOST CARE KIT EST TRACHEOST REPLE MATTRY TRASQ ELECSTIM OWND PT REPLCMT BULB/LAMP UV LGHT TX SYS EA	additional information. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500.	HHO-DE-MP-1072 Oxygen	
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A4623 A4624 A4625 A4626 A4627 A4628 A4629 A4630 A4633 A4633	TRACHEOSTOM Y INNER CANNULA TRACHEOSTOM Y INNER CANNULA TRACHEOST CARE KIT NEW TRACHEOST TRACHEOSTOM Y CLEANING BRUSH EACH SPACR BAG/RESRVOR METRD DOSE INHAL OROPHARYNGEAL SUCTION CATHETRE RACH TRACHEOST CARE KIT EST TRACHEOST REPL BATTRY TRNSQ ELEC STIM OWND PT REPLOMT BULB/TALMP UV LIGHT TX SYS EA REPLCMT BULB/TALGHT BOX TABOP MOL UNDERARM PAD CRUTCH REPLACEMENT EA	additional information. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500.	HHO-DE-MP-1072 Oxygen	
A4623 A4624 A4625 A4626 A4627 A4628 A4629 A4630 A4633 A4634 A4634 A4634	TRACHEOSTOM Y INNER CANNULA TRACHEOST CARE KIT NEW TRACHEOST TRACHEOST CARE KIT NEW TRACHEOST TRACHEOSTOMY CLEANING BRUSH EACH SPACE BAG/RESRVOR METRO DOSE INHAL OROPHARYINGEAL SUCTION CATHETER EACH TRACHEOST CARE KIT EST TRACHEOST REPL BATTRY TRNSQ ELEC STIM OWND PT REPLEATTRY TRNSQ ELEC STIM OWND PT	additional information. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500.	HHO-DE-MP-1072 Oxygen	

A4638				
A4638 A4639	REPL BATT PT-OWND EAR PULSE GEN EA REPL PAD INFRARD HEATING PAD SYS EA	Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500.		
A4639	Replacement pad for use with medically necessary alternating pressure pad owned by	Prior authorization is required for billed charges greater than \$500. Reference policies for		
A4640	patient	additional information.	HHO-DE-MP-1183 Beds, Accessories and Related Items	
A4649	Surgical supply; miscellaneous	Prior authorization is required for billed charges greater than \$500.		
A4651	CALIBRATED MICROCAPILLARY TUBE EACH	Prior authorization is required when the billed charges are greater than \$500.		
A4652	MICROCAPILLARY TUBE SEALANT	Prior authorization is required when the billed charges are greater than \$500.		
		Prior authorization is required for billed charges greater than \$500. Reference policies for		
A4653	PERITON DIALYSIS CATH ANCHR BELT EA	additional information.	HHO-DE-MP-1246 Home Dialysis Equipment and Supplies	
A4657	SYRINGE WITH OR WITHOUT NEEDLE EACH	Prior authorization is required for billed charges greater than \$500.		
A4660	SPHYGMOMANOMETER/BP W/CUFF&STETH	Prior authorization is required for billed charges greater than \$500. Reference policies for	HHO-DE-MP-1246 Home Dialysis Equipment and Supplies	
A4000	SFIT GWOWANOWETER, BF W/COFF&STETT	additional information.	The below receiver and supplies	
A4663	BLOOD PRESSURE CUFF ONLY	Prior authorization is required for billed charges greater than \$500. Reference policies for	HHO-DE-MP-1246 Home Dialysis Equipment and Supplies	
		additional information.	····· ··· - ··· · ··· · ··· · ··· · · ··· · · · · ·	
A4670	AUTOMATIC BLOOD PRESSURE MONITOR	Prior authorization is required for billed charges greater than \$500. Reference policies for	HHO-DE-MP-1246 Home Dialysis Equipment and Supplies	
		additional information.	,	
A4671	DISPBL CYCLR SET USED W/CYCLR DIALY	Prior authorization is required for billed charges greater than \$500. Reference policies for additional information.	HHO-DE-MP-1246 Home Dialysis Equipment and Supplies	
A4672	DRAIN EXT LINE STERILE DIALYSIS EA	Prior authorization is required for billed charges greater than \$500. Reference policies for additional information.	HHO-DE-MP-1246 Home Dialysis Equipment and Supplies	
		Prior authorization is required for billed charges greater than \$500. Reference policies for		
A4673	EXT LINE W/EASY LOCK CNCTR DIALYSIS	additional information.	HHO-DE-MP-1246 Home Dialysis Equipment and Supplies	
		Prior authorization is required for billed charges greater than \$500. Reference policies for		
A4674	CHEMS/ANTISPTC SOL CLEAN/STERL 80Z	additional information.	HHO-DE-MP-1246 Home Dialysis Equipment and Supplies	
A4680	ACTIVATED CARBON FILTER HEMODIAL EA	Prior authorization is required when the billed charges are greater than \$500.		
A4690	DIALYZER ALL TYPES SZS HEMODIAL EA	Prior authorization is required when the billed charges are greater than \$500.		
A4706	BICARBONATE CONC SOL HEMODIAL-GAL	Prior authorization is required when the billed charges are greater than \$500.		
A4707	BICARBONAT CONC PWDR HEMODIAL-PCKET	Prior authorization is required when the billed charges are greater than \$500.		
A4708	ACTAT CONC SOL HEMODIAL-GALLON	Prior authorization is required when the billed charges are greater than \$500.		
A4709	ACID CONC SOL HEMODIAL-GALLON	Prior authorization is required when the billed charges are greater than \$500.		
A4714	TREATED H2O PERITON DIALYSIS-GALLON	Prior authorization is required when the billed charges are greater than \$500.		
A4719	Y SET TUBING PERITONEAL DIALYSIS	Prior authorization is required when the billed charges are greater than \$500.		
A4720	DIALYSATE FL>249<=999 CC DIALYSIS	Prior authorization is required when the billed charges are greater than \$500.		
A4721	DIALYSATE FL>999<=1999CC DIALYSIS	Prior authorization is required when the billed charges are greater than \$500.		
A4722	DIALYSATE FL>1999<=2999CC DIALYSIS	Prior authorization is required when the billed charges are greater than \$500.		
A4723	DIALYSATE FL>2999<=3999CC DIALYSIS	Prior authorization is required when the billed charges are greater than \$500.		
A4724	DIALYSATE FL>3999<=4999CC DIALYSIS	Prior authorization is required when the billed charges are greater than \$500.		
A4725	DIALYSATE FL>4999<=5999CC DIALYSIS	Prior authorization is required when the billed charges are greater than \$500.		
A4726	DIALYSATE DEXTROSE FL>5999 CC PD	Prior authorization is required when the billed charges are greater than \$500.		
A4728	DIALYSAT SOL NO-DXTRS CNTAIN 500 ML	Prior authorization is required for billed charges greater than \$500. Reference policies for	HHO-DE-MP-1246 Home Dialysis Equipment and Supplies	
		additional information.	· · · · · //·· · · · · · · · · · · · ·	
A4730	FIST CANNULAT SET HEMODIALYSIS EA	Prior authorization is required when the billed charges are greater than \$500.		
A4736	TOPICAL ANESTHETIC DIALYSIS PER G	Prior authorization is required when the billed charges are greater than \$500.		
A4737	INJ ANESTHETIC DIALYSIS PER 10 ML	Prior authorization is required when the billed charges are greater than \$500.		
A4740	SHUNT ACCESSRY HEMODIAL ANY TYPE EA	Prior authorization is required when the billed charges are greater than \$500.		
A4750	BLD TUBING ART/VENOUS HEMODIAL EA	Prior authorization is required when the billed charges are greater than \$500.		
A4755 A4760	BLD TUBING ART&VENOUS HEMODIAL EA DIALYSATE SOL TST KIT PERITON EA	Prior authorization is required when the billed charges are greater than \$500.		
		Prior authorization is required when the billed charges are greater than \$500.		
A4765 A4766	DIALYSATE POWDER PERITON DIALYSIS	Prior authorization is required when the billed charges are greater than \$500.		
A4766 A4770	DIALYSATE SOL PERITON DIALYSIS-10ML BLD COLLECTION TUBE VAC DIALYSIS-50	Prior authorization is required when the billed charges are greater than \$500.		
A4770 A4771	SERUM CLOT TIME TUBE DIALYSIS-50	Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500.		
A4771 A4772	BLD GLU TEST STRIPS DIALYSIS-S0	Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500.		
A4772 A4773	OCCULT BLD TEST STRIPS DIALYSIS PERSO	Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500.		
A4773 A4774	AMMONIA TEST STRIPS DIALYSIS-50	Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500.		
A4774 A4802	PROTAMINE SULFATE HEMODIAL-50 MG	Prior authorization is required when the billed charges are greater than \$500.		
A4802 A4860	DISPBL CATH TIP PERITON DIALYSIS-10	Prior authorization is required when the billed charges are greater than \$500.		
A4800 A4870	PLUMB &/ ELEC WRK HOM HEMODIAL EQP	Prior authorization is required when the billed charges are greater than \$500.		
A4870 A4890	CONTRACTS REPR&MAINT HEMODIAL EQP	Prior authorization is required when the billed charges are greater than \$500.		
A4850 A4911	DRAIN BAG/BOTTLE FOR DIALYSIS EACH	Prior authorization is required when the billed charges are greater than \$500.		
A4913	Miscellaneous dialysis supplies, not otherwise specified	Prior authorization is required when the bined charges are greater than \$500.		
A4918	VENOUS PRESSURE CLAMP HEMODIAL EA	Prior authorization is required when the billed charges are greater than \$500.		
		Prior authorization is required for billed charges greater than \$500. Reference policies for		
A4927	GLOVES NON-STERILE PER 100	additional information.	HHO-DE-MP-1246 Home Dialysis Equipment and Supplies	
A4928	SURGICAL MASK PER 20	Prior authorization is required when the billed charges are greater than \$500.		
A4929	TOURNIQUET FOR DIALYSIS EACH	Prior authorization is required when the billed charges are greater than \$500.		
44030		Prior authorization is required for billed charges greater than \$500. Reference policies for	HUO DE MD 1346 Home Dialusis Faulterent and C	
A4930	GLOVES STERILE PER PAIR	additional information.	HHO-DE-MP-1246 Home Dialysis Equipment and Supplies	

A4932	RECTAL THERMOMETER REUSBL TYPE EA	Prior authorization is required when the billed charges are greater than \$500.	
A5051	OST POUCH CLOS; W/BARRIER ATTCH EA	Prior authorization is required when the billed charges are greater than \$500.	
A5052	OST POUCH CLOS; W/O BARR ATTACH EA	Prior authorization is required when the billed charges are greater than \$500.	
A5053	OSTOMY POUCH CLOS; USE FACEPLATE EA	Prior authorization is required when the billed charges are greater than \$500.	
A5054	OST POUCH CLOS; BARRIER W/FLNGE EA	Prior authorization is required when the billed charges are greater than \$500.	
A5055	STOMA CAP	Prior authorization is required when the billed charges are greater than \$500.	
A5056	OST POUCH DRAIN EXT BARRIER FLTR EA	Prior authorization is required when the billed charges are greater than \$500.	
A5057	OST POUCH DRAIN BARR CONVX FLTR EA	Prior authorization is required when the billed charges are greater than \$500.	
A5061	OST POUCH DRNABLE; W/BARR ATTCH EA	Prior authorization is required when the billed charges are greater than \$500.	
A5062	OST POUCH DRNABL: W/O BARR ATTCH EA	Prior authorization is required when the billed charges are greater than \$500.	
A5063	OST POUCH DRNABLE; BARR W/FLNGE EA	Prior authorization is required when the billed charges are greater than \$500.	
A5071	OST POUCH URIN; W/BARRIER ATTCH EA	Prior authorization is required when the billed charges are greater than \$500.	
A5072	OST POUCH URIN; W/O BARR ATTCH EA	Prior authorization is required when the billed charges are greater than \$500.	
A5073	OST POUCH URIN; BARRIER W/FLNGE EA	Prior authorization is required when the billed charges are greater than \$500.	
A5081	STOMA PLUG OR SEAL ANY TYPE	Prior authorization is required when the billed charges are greater than \$500.	
A5082	CONTINENT DEVC;CATH CONTINENT STOMA	Prior authorization is required when the billed charges are greater than \$500.	
A5083	CONT DEVICE STOMA ABSORPTIVE COVER	Prior authorization is required when the billed charges are greater than \$500.	
A5083	OSTOMY ACCESSORY; CONVEX INSERT	Prior authorization is required when the billed charges are greater than \$500.	
A5033	BEDSIDE DRN BOTTLE W/WO TUBING EA	Prior authorization is required when the billed charges are greater than \$500.	
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A5105 A5112	URIN SUSPENSRY LEG BAG W/WO TUBE EA URINARY DRAIN BAG LEG/ABD LATEX EA	Prior authorization is required when the billed charges are greater than \$500.	l
	URINARY DRAIN BAG LEG/ABD LATEX EA LEG STRAP; LATEX REPLCMT ONLY-SET	Prior authorization is required when the billed charges are greater than \$500.	
A5113		Prior authorization is required when the billed charges are greater than \$500.	
A5114	LEG STRAP; FOAM/FABRIC REPL-SET	Prior authorization is required when the billed charges are greater than \$500.	
A5120	SKIN BARRIER WIPES OR SWABS EACH	Prior authorization is required when the billed charges are greater than \$500.	
A5121	SKN BARRIER; SOLID 6X6/EQUVALNT EA	Prior authorization is required when the billed charges are greater than \$500.	
A5122	SKN BARRIER; SOLID 8X8/EQUVALNT EA	Prior authorization is required when the billed charges are greater than \$500.	
A5126	ADHES/NON-ADHES; DISK/FOAM PAD	Prior authorization is required when the billed charges are greater than \$500.	
A5131	APPLINC CLNR INCONT&OST APPLN-16 OZ	Prior authorization is required when the billed charges are greater than \$500.	
A5200	PERQ CATH/TUBE ANCHR DEVC ADHES SKN	Prior authorization is required when the billed charges are greater than \$500.	
A5500	DM ONLY CSTM PREP SHOE MX DNS INSRT	Prior authorization is required when the billed charges are greater than \$500.	
A5501	DM ONLY CSTM PREP SHOE MOLD PTS FT	Prior authorization is required when the billed charges are greater than \$500.	
A5503	DM ONLY MOD SHOE/CSTM ROLLER/ROCKER	Prior authorization is required when the billed charges are greater than \$500.	
A5504	DM ONLY MOD SHOE/CSTM W/WEDGE SHOE	Prior authorization is required when the billed charges are greater than \$500.	
A5505	DM ONLY MOD SHOE/CSTM W/MT BAR SHOE	Prior authorization is required when the billed charges are greater than \$500.	
A5505 A5506	DM ONLY MOD SHOE/CSTM W/MT BAR SHOE DM ONLY MOD SHOE/CSTM OFF SET HEEL	Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500.	
A5506		Prior authorization is required when the billed charges are greater than \$500.	
A5506 A5507	DM ONLY MOD SHOE/CSTM OFF SET HEEL For diabetics only, not otherwise specified modification (including fitting) of off-the-shelf depth-inlay shoe or custom-molded shoe, per shoe	Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required for billed charges greater than \$500.	
A5506 A5507 A5508	DM ONLY MOD SHOE/CSTM OFF SET HEEL For diabetics only, not otherwise specified modification (including fitting) of off-the-shelf depth-inlay shoe or custom-molded shoe, per shoe DM ONLY DELUX FEATUR SHOE/CSTM MOLD	Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required for billed charges greater than \$500. Prior authorization is required when the billed charges are greater than \$500.	
A5506 A5507 A5508 A5510	DM ONLY MOD SHOE/CSTM OFF SET HEEL For diabetics only, not otherwise specified modification (including fitting) of off-the-shelf depth-inlay shoe or custom-molded shoe, per shoe DM ONLY DELUX FEATUR SHOE/CSTM MOLD DIAB ONLY DIR FORM COMPRS MOLD FT	Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required for billed charges greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500.	
A5506 A5507 A5508 A5510 A5512	DM ONLY MOD SHOE/CSTM OFF SET HEEL For diabetics only, not otherwise specified modification (including fitting) of off-the-shelf depth-inlay shoe or custom-molded shoe, per shoe DM ONLY DELUX FEATUR SHOE/CSTM MOLD	Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required for billed charges greater than \$500. Prior authorization is required when the billed charges are greater than \$500.	
A5506 A5507 A5508 A5510	DM ONLY MOD SHOE/CSTM OFF SET HEEL For diabetics only, not otherwise specified modification (including fitting) of off-the-shelf depth-inlay shoe or custom-molded shoe, per shoe DM ONLY DELUX FEATUR SHOE/CSTM MOLD DIAB ONLY DIR FORM COMPRS MOLD FT	Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required for billed charges greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500.	
A5506 A5507 A5508 A5510 A5512	DM ONLY MOD SHOE/CSTM OFF SET HEEL For diabetics only, not otherwise specified modification (including fitting) of off-the-shelf depth-inlay shoe or custom-molded shoe, per shoe DM ONLY DELUX FEATUR SHOE/CSTM MOLD DIAB ONLY DIR FORM COMPRS MOLD FT FOR DIAB ONLY MX DNSITY INSRT PRFAB	Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required for billed charges greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500.	
A5506 A5507 A5508 A5510 A5512 A5513	DM ONLY MOD SHOE/CSTM OFF SET HEEL For diabetics only, not otherwise specified modification (including fitting) of off-the-shelf depth-inligh shoe or custom-molded shoe, per shoe DM ONLY DELUX FEATUR SHOE/CSTM MOLD DIAB ONLY DIRFORM COMPRES MOLD FT FOR DIAB ONLY MX DNISTY INSRT PRFAB DIA ONLY MX DN INSRT CSTM MLD P F E	Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required for billed charges greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500.	Image: Constraint of the second sec
A5506 A5507 A5508 A5510 A5512 A5513 A5514	DM ONLY MOD SHOE/CSTM OFF SET HEEL For diabetics only, not otherwise specified modification (including fitting) of off-the-shelf depth-inlay shoe or custom-molded shoe, per shoe DM ONLY DELUX FEATUR SHOE/CSTM MOLD DIAB ONLY DIELVIR FORM COMPRES MOLD FT FOR DIAB ONLY MX DNISTY INSRT PRFAB DIA ONLY MX DNINSRT CSTM MLD P F DIA MX DEN INS DIR CARV CSTM FAB EA	Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required for billed charges greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500.	
A5506 A5507 A5508 A5510 A5512 A5513 A5514 A6000	DM ONLY MOD SHOE/CSTM OFF SET HEEL For diabetics only, not otherwise specified modification (including fitting) of off-the-shelf depth-inlay shoe or custom-molded shoe, per shoe DM ONLY DELUX FEATUR SHOE/CSTM MOLD DIAB ONLY DIELW FEATUR SHOE/CSTM MOLD FT FOR DIAB ONLY MX DNSITY INSRT PRFAB DIA ONLY MX DN INSRT CSTM MLD P F E DIA MX DEN INS DIR CARV CSTM FAB EA NON-CNTC WND WARMING COVR W/DEVC	Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required for billed charges greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500.	
A5506 A5507 A5508 A5510 A5512 A5513 A5514 A6000 A6010	DM ONLY MOD SHOE/CSTM OFF SET HEEL For diabetics only, not otherwise specified modification (including fitting) of off-the-shelf depth-inlay shoe or custom-molded shoe, per shoe DM ONLY DELUX FEATUR SHOE/CSTM MOLD DIAB ONLY DIELW FEATUR SHOE/CSTM MOLD FT FOR DIAB ONLY MX DNINSRT OSTM MID P F E DIA ONLY MX DNINSRT CSTM FAB EA NON-CNTC WND WARMING GOVR W/DEVC COLLEGEN WOUND FILLR DRY FORM PER G	Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required for billed charges greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500.	Image: Constraint of the sector of
A5506 A5507 A5508 A5510 A5512 A5513 A5514 A6000 A6010 A6011	DM ONLY MOD SHOE/CSTM OFF SET HEEL For diabetics only, not otherwise specified modification (including fitting) of off-the-shelf depth-inligh shoe or custom-molded shoe, per shoe DM ONLY DELUX FEATUR SHOE/CSTM MOLD DIAB ONLY DIFFORM COMPRS MOLD FT FOR DIAB ONLY MX DNISTY INSRT PRFAB DIA ONLY MX DNISRT CSTM MILD PF E DIA MX DEN INS DIR CARV CSTM FAB EA NON-CNTC WND WARMING COVR W/DEVC COLLEGEN WOUND FIL GEL/PASTE PER G	Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required for billed charges greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500.	Image: Constraint of the sector of
A5506 A5507 A5508 A5510 A5512 A5513 A5514 A6000 A6010 A6011 A6021	DM ONLY MOD SHOE/CSTM OFF SET HEEL For diabetics only, not otherwise specified modification (including fitting) of off-the-shelf depth-inlay shoe or custom-molded shoe, per shoe DM ONLY DELUX FEATUR SHOE/CSTM MOLD DIAB ONLY DIELV FEATUR SHOE/CSTM MOLD FT FOR DIAB ONLY MX DNSITY INSRT PRFAB DIA ONLY MX DNISTR CSTM MLD F FE DIA MX DEN INS DIR CARV CSTM FAB EA NON-CNTC WND WARMING COVR W/DEVC COLLEGEN WOUND FILLR DRY FORM PER G COLLEGEN WOUND FILL GEL/PASTE PER G COLL DRESS PAD SIZE 16 SQ/LESS EA	Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required for billed charges greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500.	Image: Constraint of the sector of
A5506 A5507 A5508 A5510 A5512 A5513 A5514 A6000 A6010 A6011 A6021 A6022	DM ONLY MOD SHOE/CSTM OFF SET HEEL For diabetics only, not otherwise specified modification (including fitting) of off-the-shelf depth-inlay shoe or custom-molded shoe, per shoe DM ONLY DELUX FEATUR SHOE/CSTM MOLD DIAB ONLY DIL FORM COMPRS MOLD FT FOR DIAB ONLY MX DNSITY INSRT PRFAB DIA ONLY MX DN INSRT CSTM MLD P F DIA MX DEN INS DIR CARV CSTM FAB EA NON-CNTC WND WARMING COVR W/DEVC COLLEGEN WOUND FILLR DRY FORM PER G COLLEGEN WOUND FIL GEL/PASTE PER G COLL DRESS PAD SIZE 16 SQL'ESS EA COLL DRSG STRL>16 BUT <td>Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required for billed charges greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500.</td> <td>Image: Constraint of the sector of</td>	Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required for billed charges greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500.	Image: Constraint of the sector of
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A6216	GAUZE NON-IM PREG NONSTERL 16 SQ/<	Prior authorization is required when the billed charges are greater than \$500.	
A6217	GAUZE NON-IMPREG NONSTRL >16<=48SQ	Prior authorization is required when the billed charges are greater than \$500.	
A6218	GAUZE NON-IM PREG NONSTERL > 48 SQ	Prior authorization is required when the billed charges are greater than \$500.	
A6219	GAUZE NON-IMPREG STERL 16 SQ/ <adhes< td=""><td>Prior authorization is required when the billed charges are greater than \$500.</td><td></td></adhes<>	Prior authorization is required when the billed charges are greater than \$500.	
A6220	GAUZE NON-IMPREG >16 <=48 SQ ADHES	Prior authorization is required when the billed charges are greater than \$500.	
A6221	GAUZE NON-IMPREG > 48 SQ W/ADHES	Prior authorization is required when the billed charges are greater than \$500.	
A6222	GAUZ IMPREG NOT H20/HYDRGEL 16 SQ/<	Prior authorization is required when the billed charges are greater than \$500.	
A6223	GAUZ IMPREG NOT H2O/HYDRGL>16<=48	Prior authorization is required when the billed charges are greater than \$500.	
A6224	GAUZ IMPREG NOT H20/HYDROGEL>48 SQ	Prior authorization is required when the billed charges are greater than \$500.	
A6228	GAUZ IMPREG WATR/NL SALINE > 16 SQ	Prior authorization is required when the billed charges are greater than \$500.	<u> </u>
A6229	GAUZ IMPREG WATR/SALINE >16/54	Prior authorization is required when the billed charges are greater than \$500.	
A6230	GAUZ IMPREG H2O/SALINE STERL >48 SQ	Prior authorization is required when the billed charges are greater than \$500.	
A6230	GAUZ IMPREG HZD/SALINE STELL >48 SQ	Prior authorization is required when the billed charges are greater than \$500.	
A6231	GAUZ IMPREG HYDRGEL DIR WIND 10 50/<	Prior authorization is required when the billed charges are greater than \$500.	
A6233 A6234	GAUZ IMPREG HYDRGEL DIR WND > 48 SQ	Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500.	
	HYDRCOLLOID DRESS 16 SQ/< W/O ADHES		
A6235	HYDRCOLLOID DRESS >16<=48 NO ADHES	Prior authorization is required when the billed charges are greater than \$500.	
A6236	HYDROCOLLOID DRESS >48 SQ W/O ADHES	Prior authorization is required when the billed charges are greater than \$500.	
A6237	HYDROCOLLOID DRESS 16 SQ/< W/ADHES	Prior authorization is required when the billed charges are greater than \$500.	
A6238	HYDRCOLLOID DRESS >16<= 48 W/ADHES	Prior authorization is required when the billed charges are greater than \$500.	Į
A6239	HYDROCOLLOID DRESS > 48 SQ W/ADHES	Prior authorization is required when the billed charges are greater than \$500.	ļ
A6240	HYDROCOLLOID DRESS FIL PASTE-FL OZ	Prior authorization is required when the billed charges are greater than \$500.	
A6241	HYDROCOLLOID DRESS DRY FORM PER G	Prior authorization is required when the billed charges are greater than \$500.	
A6242	HYDROGEL DRESS 16 SQ/< W/O ADHES EA	Prior authorization is required when the billed charges are greater than \$500.	
A6243	HYDROGEL DRESS >16 <=48SQ NO ADHES	Prior authorization is required when the billed charges are greater than \$500.	
A6244	HYDROGEL DRESS > 48 SQ W/O ADHES EA	Prior authorization is required when the billed charges are greater than \$500.	
A6245	HYDROGEL DRESS 16 SQ/< W/ADHES EA	Prior authorization is required when the billed charges are greater than \$500.	
A6246	HYDROGEL DRESS >16 <=48 SQ W/ADHES	Prior authorization is required when the billed charges are greater than \$500.	
A6247	HYDROGEL DRESS STERL >48 SQ ADHES	Prior authorization is required when the billed charges are greater than \$500.	
A6248	HYDROGEL DRESS WOUND FIL GEL FL OZ	Prior authorization is required when the billed charges are greater than \$500.	
A6250	SKN SEALNT PROTCT MOISTURZR OINTMNT	Prior authorization is required when the billed charges are greater than \$500.	1
A6251	SPCLTY ABSORB DRESS 16SQ/< NO ADHES	Prior authorization is required when the billed charges are greater than \$500.	
A6252	SPCL ABSORB DRESS >16<=48 NO ADHES	Prior authorization is required when the billed charges are greater than \$500.	
A6253	SPCLTY ABSORB DRESS >48 SQ NO ADHES	Prior authorization is required when the billed charges are greater than \$500.	
A6254	SPCLTY ABSORB DRESS 14 BSQ RD HDHES	Prior authorization is required when the billed charges are greater than \$500.	
A6255	SPCL ABSORB DRESS >16<= 48 W/ADHES	Prior authorization is required when the billed charges are greater than \$500.	
A6255	SPCLTY ABSORB DRESS > 48 SQ W/ADHES	Prior authorization is required when the billed charges are greater than \$500.	
A6250	TRNSPRT FILM STERL 16 SQ/< EA DRESS	Prior authorization is required when the billed charges are greater than \$500.	
A6258	TRNSPRT FILM >16 SQ BUT <=48 SQ EA	Prior authorization is required when the billed charges are greater than \$500.	
A6259	TRNSPRT FILM STERL > 48 SQ EA		
		Prior authorization is required when the billed charges are greater than \$500.	
A6260	WOUND CLEANSERS ANY TYPE ANY SIZE	Prior authorization is required when the billed charges are greater than \$500.	
A6261	Wound filler, gel/paste, per fluid ounce, not otherwise specified	Prior authorization is required for billed charges greater than \$500.	
A6262 A6266	Wound filler, dry form, per gram, not otherwise specified	Prior authorization is required for billed charges greater than \$500.	
	GAUZ IMPRG NOT H2O SAL/ZINC LINR YD	Prior authorization is required when the billed charges are greater than \$500.	
A6402	GAUZ NON-IMPREG STERL 16 SQ/< NO AD	Prior authorization is required when the billed charges are greater than \$500.	
A6403	GAUZ NON-IMPREG STERL >16 <= 48 SQ	Prior authorization is required when the billed charges are greater than \$500.	
A6404	GAUZ NON-IMPREG STRL >48SQ NO ADHES	Prior authorization is required when the billed charges are greater than \$500.	↓
A6407	PACK STRIPS NON-IMPREGNTD UP 2 IN	Prior authorization is required when the billed charges are greater than \$500.	ļ
A6410	EYE PAD STERILE EACH	Prior authorization is required when the billed charges are greater than \$500.	
A6411	EYE PAD NON-STERILE EACH	Prior authorization is required when the billed charges are greater than \$500.	
A6412	EYE PATCH OCCLUSIVE EACH	Prior authorization is required when the billed charges are greater than \$500.	
A6413	ADHESIVE BANDAGE FIRST-AID TYPE EA	Prior authorization is required when the billed charges are greater than \$500.	
A6441	PADD BANDGE NON-ELAST NON-WOVEN/NON	Prior authorization is required when the billed charges are greater than \$500.	
A6442	CONFORMING BANDGE NON-ELAST KNITTED	Prior authorization is required when the billed charges are greater than \$500.	
A6443	CONFORMING BANDGE NON-ELAST KNITTED	Prior authorization is required when the billed charges are greater than \$500.	
A6444	CONFORMING BANDGE NON-ELAST KNITTED	Prior authorization is required when the billed charges are greater than \$500.	
A6445	CONFORMING BANDGE NON-ELAST KNITTED	Prior authorization is required when the billed charges are greater than \$500.	
A6446	CONFORMING BANDGE NON-ELAST KNITTED	Prior authorization is required when the billed charges are greater than \$500.	<u>† </u>
A6447	CONFORMING BANDGE NON-ELAST KNITTED	Prior authorization is required when the billed charges are greater than \$500.	t
A6448	LT COMPRS BANDGE ELAST WDTH < 3 IN	Prior authorization is required when the billed charges are greater than \$500.	<u> </u>
A6449	LT COMPRS BANDGE WDTH >/= 3 & <5 IN	Prior authorization is required when the billed charges are greater than \$500.	<u> </u>
A6450	LT COMPRS BANDGE WDTH >/= 5 IN	Prior authorization is required when the billed charges are greater than \$500.	<u> </u>
A6450	MOD COMPRS BANDGE WD >/= 3 & <5 IN	Prior authorization is required when the billed charges are greater than \$500.	<u> </u>
A6451 A6452	HI COMPRS BANDGE WD >/= 3 & <5 IN	Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500.	<u>├</u> ──────────
A6452 A6453	HI COMPRS BANDGE WD >/= 3 & <5 IN SELF-ADHERENT BANDGE WDTH = 3 IN</td <td></td> <td>ł</td>		ł
A6453 A6454	SELF-ADHERENT BANDGE WDTH = 3 IN<br SLF ADHERNT BANDGE WD >/= 3 & <5 IN	Prior authorization is required when the billed charges are greater than \$500.	<u>├</u> ─────────
A0454		Prior authorization is required when the billed charges are greater than \$500.	l
AC 155			
A6455 A6456	SELF-ADHERENT BANDGE WDTH >/= 5 IN ZINC PAST BANDGE WD >/= 3 & <5 IN	Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500.	

A6457	TUBULR DRSG W/WO ELAST WDTH LINR YD	Prior authorization is required when the billed charges are greater than \$500.		
A6460	SYN RSRB W DR STRL P 16 SI/< NO A E	Prior authorization is required when the billed charges are greater than \$500.		
A6461	S RSRB ST PD SZ >16 SI = 48 SI E</td <td>Prior authorization is required when the billed charges are greater than \$500.</td> <td></td> <td></td>	Prior authorization is required when the billed charges are greater than \$500.		
A6501	COMPRS BURN GARMNT BDYSUIT CSTM FAB	Prior authorization is required when the billed charges are greater than \$500.		
A6502	COMPRS BRN GARMNT CHIN STRAP CSTM	Prior authorization is required when the billed charges are greater than \$500.		
A6503	COMPRS BRN GARMNT FCE HOOD CSTM FAB	Prior authorization is required when the billed charges are greater than \$500.		
A6504	COMPRS BRN GARM NT GLOV WRST CSTM	Prior authorization is required when the billed charges are greater than \$500.		
A6505	COMPRS BRN GARMNT GLOV ELB CSTM FAB	Prior authorization is required when the billed charges are greater than \$500.		
A6506	COMPRS BURN GARMNT GLOV AX CSTM FAB	Prior authorization is required when the billed charges are greater than \$500.		
A6507	COMPRS BRN GARMNT FT KNEE LEN CSTM	Prior authorization is required when the billed charges are greater than \$500.		
A6508	COMPRS BRN GARMNT FT THI LEN CSTM	Prior authorization is required when the billed charges are greater than \$500.		
A6509	COMPRS BRN GARM NT TRNK WAIST CSTM	Prior authorization is required when the billed charges are greater than \$500.		
A6510	COMPRS BRN GARMNT TRNK ARM LEG OPN	Prior authorization is required when the billed charges are greater than \$500.		
A6511	COMPRS BRN GARMNT LW TRNK LEG OPN	Prior authorization is required when the billed charges are greater than \$500.		
A6512	Compression burn garment, not otherwise classified	Prior authorization is required for billed charges greater than \$500.		
A6513	COMPRS BRN MASK FCE&/NCK PLSTC/EQUL	Prior authorization is required when the billed charges are greater than \$500.		
A6521	Gradient compression garment, glove, padded, for nighttime use, custom, each	Prior authorization is required when the billed charges are greater than \$500.		
A6522	Gradient compression garment, arm, padded, for nighttime use, each	Prior authorization is required when the billed charges are greater than \$500.		
A6523	Gradient compression garment, arm, padded, for nightaine use, custom, each	Prior authorization is required when the billed charges are greater than \$500.		
A6524	Gradient compression garment, lower leg and foot, padded, for nighttime use, each	Prior authorization is required when the billed charges are greater than \$500.		
	Gradient compression garment, lower leg and foot, padded, for nightaine use, custom,			
A6525	each	Prior authorization is required when the billed charges are greater than \$500.		
A6526	Gradient compression garment, full leg and foot, padded, for nighttime use, each	Prior authorization is required when the billed charges are greater than \$500.		
A6527	Gradient compression garment, full leg and foot, padded, for nighttime use, custom, each	Prior authorization is required when the billed charges are greater than \$500.		
A6528	Gradient compression garment, bra, for nighttime use, each	Prior authorization is required when the billed charges are greater than \$500.		
A6529	Gradient compression garment, bra, for nighttime use, custom, each	Prior authorization is required when the billed charges are greater than \$500.		
A6530	GRADIENT COMPRS STK BK 18-30 MMHG	Prior authorization is required when the billed charges are greater than \$500.		
A6531	Gradient compression stocking, below knee, 30-40 mmhg, used as a surgical dressing, each	Prior authorization is required when the billed charges are greater than \$500.		
A6532	Gradient compression stocking, below knee, 40-50 mmhg, used as a surgical dressing, each	Prior authorization is required when the billed charges are greater than \$500.		
A6533	GRADENT COMPRS STK THIGH 18-30 MMHG	Prior authorization is required when the billed charges are greater than \$500.		
A6534	GRADENT COMPRS STK THIGH 20-50 MMHG	Prior authorization is required when the billed charges are greater than \$500.		
A6535	Gradient compression stocking, thigh length, 40 mmhg or greater, each	Prior authorization is required when the billed charges are greater than \$500.		
A6536	GRADENT COMPRS STK FULL 18-30 MMHG	Prior authorization is required when the billed charges are greater than \$500.		
A6537	GRADENT COMPRS STK FULL 30-40 MMHG	Prior authorization is required when the billed charges are greater than \$500.		
A6538	Gradient compression stocking, full length/chap style, 40 mmhg or greater, each	Prior authorization is required when the billed charges are greater than \$500.		
A6530	GRADENT COMPRESSION Stocking, run Engels, chap style, 40 mining of greater, each	Prior authorization is required when the billed charges are greater than \$500.		
A6540	GRADENT COMPRS STR WAIST 10:50 MM/HG	Prior authorization is required when the billed charges are greater than \$500.		
A6541	Gradient compression stocking, waist length, 40 mmhg or greater, each	Prior authorization is required when the billed charges are greater than \$500.		
A6544	GRADENT COMPRESSION STK GARTER BELT	Prior authorization is required when the billed charges are greater than \$500.		
70544	Gradient compression wrap, non-elastic, below knee, 30-50 mmhg, used as a surgical	Prior autionization is required when the billed that ges are greater than \$500.		
A6545	dressing, each	Prior authorization is required when the billed charges are greater than \$500.		
A6549	Gradient compression garment, not otherwise specified	Prior authorization is required for billed charges greater than \$500.		
A6550	Wound care set, for negative pressure wound therapy electrical pump, includes all supplies and accessories	Prior authorization is required for billed charges greater than \$500. Reference policies for additional information.	HHO-DE-MP-1039 Negative Pressure Wound Therapy	
A6552	Gradient compression stocking, below knee, 30-40 mmhg, each	Prior authorization is required when the billed charges are greater than \$500.		
A6553	Gradient compression stocking, below knee, 30-40 mmhg, custom, each	Prior authorization is required when the billed charges are greater than \$500.		
A6554	Gradient compression stocking, below knee, 40 mmhg or greater, each	Prior authorization is required when the billed charges are greater than \$500.		
A6555	Gradient compression stocking, below knee, 40 mmhg or greater, custom, each	Prior authorization is required when the billed charges are greater than \$500.		
A6556	Gradient compression stocking, thigh length, 18-30 mmhg, custom, each	Prior authorization is required when the billed charges are greater than \$500.		
A6557	Gradient compression stocking, thigh length, 30-40 mmhg, custom, each	Prior authorization is required when the billed charges are greater than \$500.		
A6558	Gradient compression stocking, thigh length, 40 mmhg or greater, custom, each	Prior authorization is required when the billed charges are greater than \$500.		
A6559	Gradient compression stocking, full length/chap style, 18-30 mmhg, custom, each	Prior authorization is required when the billed charges are greater than \$500.		
A6560	Gradient compression stocking, full length/chap style, 30-40 mmhg, custom, each	Prior authorization is required when the billed charges are greater than \$500.		
A6561	Gradient compression stocking, full length/chap style, 40 mmhg or greater, custom, each	Prior authorization is required when the billed charges are greater than \$500.		
A6562	Gradient compression stocking, waist length, 18-30 mmhg, custom, each	Prior authorization is required when the billed charges are greater than \$500.		
A6563	Gradient compression stocking, waist length, 30-40 mmhg, custom, each	Prior authorization is required when the billed charges are greater than \$500.		ļ
A6564	Gradient compression stocking, waist length, 40 mmhg or greater, custom, each	Prior authorization is required when the billed charges are greater than \$500.		
A6565	Gradient compression gauntlet, custom, each	Prior authorization is required when the billed charges are greater than \$500.		ļ
A6566	Gradient compression garment, neck/head, each	Prior authorization is required when the billed charges are greater than \$500.		
A6567	Gradient compression garment, neck/head, custom, each	Prior authorization is required when the billed charges are greater than \$500.		
A6568	Gradient compression garment, torso and shoulder, each	Prior authorization is required when the billed charges are greater than \$500.		
A6569	Gradient compression garment, torso/shoulder, custom, each	Prior authorization is required when the billed charges are greater than \$500.		
A6570	Gradient compression garment, genital region, each	Prior authorization is required when the billed charges are greater than \$500.		
A6571	Gradient compression garment, genital region, custom, each	Prior authorization is required when the billed charges are greater than \$500.		
A6572	Gradient compression garment, toe caps, each	Prior authorization is required when the billed charges are greater than \$500.		

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A6573	Gradient compression garment, toe caps, custom, each	Prior authorization is required when the billed charges are greater than \$500.		
A6574	Gradient compression arm sleeve and glove combination, custom, each	Prior authorization is required when the billed charges are greater than \$500.		
A6575	Gradient compression arm sleeve and glove combination, each	Prior authorization is required when the billed charges are greater than \$500.		
A6576	Gradient compression arm sleeve, custom, medium weight, each	Prior authorization is required when the billed charges are greater than \$500.		
A6577	Gradient compression arm sleeve, custom, heavy weight, each	Prior authorization is required when the billed charges are greater than \$500.		
A6578	Gradient compression arm sleeve, each	Prior authorization is required when the billed charges are greater than \$500.		
A6579	Gradient compression glove, custom, medium weight, each	Prior authorization is required when the billed charges are greater than \$500.		
A6580	Gradient compression glove, custom, heavy weight, each	Prior authorization is required when the billed charges are greater than \$500.		
A6581	Gradient compression glove, each	Prior authorization is required when the billed charges are greater than \$500.		
A6582	Gradient compression gauntlet, each	Prior authorization is required when the billed charges are greater than \$500.		
A6583	Gradient compression wap with adjustable straps, below knee, 30-50 mmhg, each	Prior authorization is required when the billed charges are greater than \$500.		
A6584				
	Gradient compression wrap with adjustable straps, not otherwise specified	Prior authorization is required when the billed charges are greater than \$500.		
A6585	Gradient pressure wrap with adjustable straps, above knee, each	Prior authorization is required when the billed charges are greater than \$500.		
A6586	Gradient pressure wrap with adjustable straps, full leg, each	Prior authorization is required when the billed charges are greater than \$500.		
A6587	Gradient pressure wrap with adjustable straps, foot, each	Prior authorization is required when the billed charges are greater than \$500.		
A6588	Gradient pressure wrap with adjustable straps, arm, each	Prior authorization is required when the billed charges are greater than \$500.		
A6589	Gradient pressure wrap with adjustable straps, bra, each	Prior authorization is required when the billed charges are greater than \$500.		
A6593	Accessory for gradient compression garment or wrap with adjustable straps, non-otherwise specified	Prior authorization is required when the billed charges are greater than \$500.		
A6594	Gradient compression bandaging supply, bandage liner, lower extremity, any size or length, each	Prior authorization is required when the billed charges are greater than \$500.		
A6595	Gradient compression bandaging supply, bandage liner, upper extremity, any size or	Prior authorization is required when the billed charges are greater than \$500.		
A6596	length, each Gradient compression bandaging supply, conforming gauze, per linear yard, any width,			
A6596 A6597	each Gradient compression bandage roll, elastic long stretch, linear yard, any width, each	Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500.		
A6598	Gradient compression bandage roll, elastic medium stretch, per linear yard, any width, each Gradient compression bandage roll, elastic medium stretch, per linear yard, any width, each	Prior authorization is required when the billed charges are greater than \$500.		
A6599	Gradient compression bandage roll, inelastic short stretch, per linear yard, any width, each Gradient compression bandaging supply, high density foam sheet, per 250 square	Prior authorization is required when the billed charges are greater than \$500.		
A6600	centimeters, each	Prior authorization is required when the billed charges are greater than \$500.		
A6601	Gradient compression bandaging supply, high density foam pad, any size or shape, each	Prior authorization is required when the billed charges are greater than \$500.		
A6602	Gradient compression bandaging supply, high density foam roll for bandage, per linear yard, any width, each	Prior authorization is required when the billed charges are greater than \$500.		
A6603	Gradient compression bandaging supply, low density channel foam sheet, per 250 square centimeters, each	Prior authorization is required when the billed charges are greater than \$500.		
A6604	Gradient compression bandaging supply, low density flat foam sheet, per 250 square centimeters, each	Prior authorization is required when the billed charges are greater than \$500.		
A6605	Gradient compression bandaging supply, padded foam, per linear yard, any width, each	Prior authorization is required when the billed charges are greater than \$500.		
A6606	Gradient compression bandaging supply, padded textile, per linear yard, any width, each	Prior authorization is required when the billed charges are greater than \$500.		
AUUUU	Gradient compression bandaging supply, budded textue, per linear yard, any width, each Gradient compression bandaging supply, tubular protective absorption layer, per linear	The automation steparca when the bines charges are greater than 5500.		
A6607	vard. anv width. each	Prior authorization is required when the billed charges are greater than \$500.		
A6608	Gradient compression bandaging supply, tubular protective absorption padded layer, per	Prior authorization is required when the billed charges are greater than \$500.		
	linear yard, any width, each			
A6609	Gradient compression bandaging supply, not otherwise specified	Prior authorization is required when the billed charges are greater than \$500.		
A6610	Gradient compression stocking, below knee, 18-30 mmhg, custom, each	Prior authorization is required when the billed charges are greater than \$500.		
A7000	Canister, disposable, used with suction pump, each	Prior authorization is required for billed charges greater than \$500. Reference policies for additional information.	HHO-DE-MP-1039 Negative Pressure Wound Therapy	
A7001	Canister, nondisposable, used with suction pump, each	Prior authorization is required for billed charges greater than \$500. Reference policies for additional information.	HHO-DE-MP-1039 Negative Pressure Wound Therapy	
A7002	Tubing, used with suction pump, each	Prior authorization is required for billed charges greater than \$500. Reference policies for additional information.	HHO-DE-MP-1063 Devices Used for the Treatment of Obstructive Sleep Apnea in Adults	
A7003	ADMN SET SM VOL NONFILTR NEB DISPBL	Prior authorization is required when the billed charges are greater than \$500.	· · ·	1
A7004	SM VOL NONFILTR PNEUMAT NEB DISPBL	Prior authorization is required when the billed charges are greater than \$500.		
A7005	ADMN SET SM VOL NONFLTR NEB NONDISP	Prior authorization is required when the billed charges are greater than \$500.		
A7005	ADMINISET SIV VOE NONPETRINEB NONDESP	Prior authorization is required when the billed charges are greater than \$500.		
A7000	LG VOL NEBULIZR DISPBL UNFIL COMPRS	Prior authorization is required when the billed charges are greater than \$500.		<u> </u>
A7007	LG VOL NEBULIZR DISPBL ONFIL COMPRS	Prior authorization is required when the billed charges are greater than \$500.		<u> </u>
A7008 A7009	RESRVOR BOTTLE LG VOL US NEBULIZR	Prior authorization is required when the billed charges are greater than \$500.		
A7009 A7010	CORUG TUBE DISPBL LG VOL US NEBULIZK			
		Prior authorization is required when the billed charges are greater than \$500.		
A7012	WATER COLLEC DEV USE W/LG VOL NEB	Prior authorization is required when the billed charges are greater than \$500.		
A7013	FILTER DISP W/AREO COMPRESS/US GEN	Prior authorization is required when the billed charges are greater than \$500.		
A7014	FLTR NON-DISPBL AROSL COMPRS/US GEN	Prior authorization is required when the billed charges are greater than \$500.		
A7015	AREO MASK USED W/ DME NEB	Prior authorization is required when the billed charges are greater than \$500.		
A7016	DOME&MOUTHPECE W/SM VOL US NEBULIZR	Prior authorization is required when the billed charges are greater than \$500.		
A7017	NEB GLASS/AUTOCLAV NOT USE W/O2	Prior authorization is required when the billed charges are greater than \$500.		
A7018	H2O DIST USE W/LG VOL NEB 1000 ML	Prior authorization is required when the billed charges are greater than \$500.		
A7020	INTERFACE COUGH STIM DEVC REPLONLY	Prior authorization is required for billed charges greater than \$500. Reference policies for additional information.	HHO-DE-MP-1141 High Frequency Chest Wall Oscillation Devices	
		additional IIIOIIIIatioII.	Devices	1

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

A7525	TRACHEOSTOMY MASK EACH	Prior authorization is required when the billed charges are greater than \$500.		
A7526	TRACHEOSTOMY TUBE COLLAR/HOLDER EA	Prior authorization is required when the billed charges are greater than \$500.		
A7527	TRACHEOST/LRYNGCT TUBE PLUG/STOP EA	Prior authorization is required when the billed charges are greater than \$500.		
A8000	HELMET PROTECTIVE SOFT PREFAB	Prior authorization is required when the billed charges are greater than \$500.		
A8001	HELMET PROTECTIVE HARD PREFAB	Prior authorization is required when the billed charges are greater than \$500.		
A8002	HELMET PROTECTIVE SOFT CUSTOM FAB	Prior authorization is required when the billed charges are greater than \$500.		
A8003	HELMET PROTECTIVE HARD CUSTOM FAB	Prior authorization is required when the billed charges are greater than \$500.		
A8004	SOFT INTERFACE FOR HELMET REPLONLY	Prior authorization is required when the billed charges are greater than \$500.		
A9150	NONPRESCRIPTION DRUG	Prior authorization is required when the billed charges are greater than \$500.		
A9152	Single vitamin/mineral/trace element, oral, per dose, not otherwise specified	Prior authorization is required for billed charges greater than \$500.		
	Multiple vitamins, with or without minerals and trace elements, oral, per dose, not	·		
A9153	otherwise specified	Prior authorization is required for billed charges greater than \$500.		
A9155	ARTFICIAL SALIVA 30 ML	Prior authorization is required when the billed charges are greater than \$500.		
A9270	NONCOVERED ITEM OR SERVICE	Prior authorization is required when the billed charges are greater than \$500.		
A9272	WND SCTN DISPBL DRSG ACC ANY TYP EA	Prior authorization is required when the billed charges are greater than \$500.		
A9273	COLD/HOT FL BTL IC/C HT&/CLD W ANY	Prior authorization is required when the billed charges are greater than \$500.		
A9274	EXT AMB INSULIN DEL SYS DISPOSBL EA	Prior authorization is required when the billed charges are greater than \$500.		
A9275	HOME GLU DISPBL MON W/TEST STRIPS	Prior authorization is required when the billed charges are greater than \$500.		
A9276	SENSOR; INVSV INTRSTL GLU MON SYS	Prior authorization is required when the billed charges are greater than \$500.		
A9277	TRANSMTR; EXT INTRSTL CONT GLU MON	Prior authorization is required when the billed charges are greater than \$500.		
A9278	RECEIVER MON; EXT INTRSTL GLU MON	Prior authorization is required when the billed charges are greater than \$500.		
	Monitoring feature/device, stand-alone or integrated, any type, includes all accessories,			
A9279	components and electronics, not otherwise classified	Prior authorization is required for billed charges greater than \$500.		
A9280	Alert or alarm device, not otherwise classified	Prior authorization is required for billed charges greater than \$500.		İ
A9281	REACH/GRABBING DEVC ANY TYPE/LEN EA	Prior authorization is required when the billed charges are greater than \$500.		
A9282	WIG ANY TYPE EACH	Prior authorization is required when the billed charges are greater than \$500.		
A9283	FOOT PRESSURE OFF LOAD/SUPP DEV EA	Prior authorization is required when the billed charges are greater than \$500.		
A9284	SPIROMETER NONELECTRONC INCLACCESS	Prior authorization is required when the billed charges are greater than \$500.		
A9284 A9285	INVERSION/EVERSION CORRECTION DEVC	Prior authorization is required when the billed charges are greater than \$500.		
A9286	HYG I/DVC DISPBL/NON-DISPBL ANY T E	Prior authorization is required when the billed charges are greater than \$500.		
A9900	Miscellaneous dme supply, accessory and/or service component of another hcpcs code	Prior authorization is required for billed charges greater than \$500.		
A9901	DME DEL SET&/DSPNS SRVC ANOTH HCPCS	Prior authorization is required when the billed charges are greater than \$500.		
A9999	Miscellaneous dme supply or accessory, not otherwise specified	Prior authorization is required for billed charges greater than \$500.		
B4034	ENTERAL FEED SPL KIT; SYRINGE DAY	Prior authorization is required when the billed charges are greater than \$500.		
B4035	ENTERAL FEED SPL KIT; PUMP FED-DAY	Prior authorization is required when the billed charges are greater than \$500.		
B4036	ENTERAL FD SPL KIT; GRAVITY FED-DAY	Prior authorization is required when the billed charges are greater than \$500.		
B4081	NASOGASTRIC TUBING WITH STYLET	Prior authorization is required when the billed charges are greater than \$500.		
B4082	NASOGASTRIC TUBING WITHOUT STYLET	Prior authorization is required when the billed charges are greater than \$500.		
B4083	STOMACH TUBE - LEVINE TYPE	Prior authorization is required when the billed charges are greater than \$500.		
B4087	GASTROSTOMY/J-TUBE STANDARD EACH	Prior authorization is required when the billed charges are greater than \$500.		
B4087	GASTROSTOMY/J-TUBE LOW-PROFILE EA	Prior authorization is required when the billed charges are greater than \$500.		
B4088 B4100	FOOD THICKENER ADMINED ORALLY-OUNCE			
		Prior authorization is required when the billed charges are greater than \$500.		
B4102	ENTRAL F ADLT REPL FL&LYTES 500 ML	Prior authorization is required when the billed charges are greater than \$500.		
B4103	ENTRAL F PED REPL FL&LYTES 500 ML	Prior authorization is required when the billed charges are greater than \$500.		
B4104	ADDITIVE FOR ENTERAL FORMULA	Prior authorization is required when the billed charges are greater than \$500.		
B4105	In-line cartridge containing digestive enzyme(s) for enteral feeding, each	Not covered for member ages 5 and under. Prior authorization is required when the billed	HHO-DE-MP-1010 Enteral Feeding In-Line Cartridge	
64105	maine cardidge containing digestive enzyme(s) for enteral recurring, each	charges are greater than \$500. Reference policies for additional information.	Thro-be-wir-1010 Enteral reeding in-Ente callinge	
		Prior authorization is required when the billed charges are greater than \$500.		
B4149	ENTRAL F MANF BLNDRIZD NAT FOODS	Reference policies for additional information.	HHO-DE-MP-1010 Enteral Feeding In-Line Cartridge	
		Prior authorization is required when the billed charges are greater than \$500.		
B4150	ENTRAL F NUTRITIONALLY COMPLETE	Reference policies for additional information.	HHO-DE-MP-1010 Enteral Feeding In-Line Cartridge	
		· · · · · · · · · · · · · · · · · · ·		
		Prior authorization is required when the billed charges are greater than \$500.		
B4152	ENTRAL F NUTRITION CMPL CAL DENSE	Reference policies for additional information.	HHO-DE-MP-1010 Enteral Feeding In-Line Cartridge	
0+132		nelective poneles for additional mormation.		
B4153	ENTRL F NUTRTN CMPL HYDROLYZD PROTS	Prior authorization is required when the billed charges are greater than \$500.		1
B4153 B4154				
	ENTRAL F CMPL NO INHERITED DZ METAB	Prior authorization is required when the billed charges are greater than \$500.		
B4155	ENTRAL F NUTRITN INCMPL/MOD NUTRNTS	Prior authorization is required when the billed charges are greater than \$500.		
		Prior authorization is required when the billed charges are greater than \$500.		
B4157	ENTRAL F CMPLINHERITED DZ METAB	Reference policies for additional information.	HHO-DE-MP-1010 Enteral Feeding In-Line Cartridge	
B4158	ENTRAL F PED NUTRITION COMPLETE	Prior authorization is required when the billed charges are greater than \$500.		
B4159	ENTRAL F PED NUTRITN CMPL SOY BASD	Prior authorization is required when the billed charges are greater than \$500.		
B4160	ENTRAL F PED NUTRITN CMPL CAL DENSE	Prior authorization is required when the billed charges are greater than \$500.		
B4161	ENTRAL F PED HYDROLYZED/AA PROTEINS	Prior authorization is required when the billed charges are greater than \$500.		
		Prior authorization is required when the billed charges are greater than \$500.		
1	ENTRAL F PED INHERITED DZ METAB	Reference policies for additional information.	HHO-DE-MP-1010 Enteral Feeding In-Line Cartridge	
B4162				1
B4162				

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B4164	PARNTRAL NUT SOL; CARBS 50%/< HOM	Prior authorization is required when the billed charges are greater than \$500.	
B4168 B4172	PARNTRAL NUT SOL; AMINO ACID 3.5% PARNTRAL NUT SOL; AMINO ACID 5.5-7%	Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500.	
B4172 B4176			
B4176 B4178	PARNTRAL NUT SOL; AMINO ACID 7-8.5% PARNTRAL NUT SOL; AMINO ACID > 8.5%	Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500.	
B4178 B4180	PARNTRAL NUT SOL; AMTNO ACID > 8.5% PARNTRAL NUT SOL; CARBS > 50% HOM	Prior authorization is required when the billed charges are greater than \$500.	
B4180 B4185	Parenteral nutrition solution, not otherwise specified, 10 grams lipids	Prior authorization is required for billed charges greater than \$500.	
B4185 B4187	OMEGAVEN 10 G LIPIDS	Prior authorization is required when the billed charges are greater than \$500.	
B4189	PARNTRAL NUT;AMINOACID&CARB 10-51GM	Prior authorization is required when the billed charges are greater than \$500.	
B4103	PARNTRAL NUT; AMINOACID&CARD 10 515M	Prior authorization is required when the billed charges are greater than \$500.	
B4197	PARNTRL NUT; AMINOACID&CARB 74-100GM	Prior authorization is required when the billed charges are greater than \$500.	
B4199	PARNTRAL NUT;AMINO ACID&CARB >100GM	Prior authorization is required when the billed charges are greater than \$500.	
B4216	PARNTRAL NUT; ADDITIVES-HOM MIX-DAY	Prior authorization is required when the billed charges are greater than \$500.	
B4220	PARNTRAL NUTRIT SPL KIT; PREMIX-DAY	Prior authorization is required when the billed charges are greater than \$500.	
B4222	PARNTRAL NUT SPL KIT; HOM MIX-DAY	Prior authorization is required when the billed charges are greater than \$500.	
B4224	PARNTRAL NUTRITION ADMIN KIT-DAY	Prior authorization is required when the billed charges are greater than \$500.	
B5000	PARNTRAL NUT; AMINO ACID&CARBS RENL	Prior authorization is required when the billed charges are greater than \$500.	
B5100	PARENTERL NUT SOL AMINO ACID & CARB	Prior authorization is required when the billed charges are greater than \$500.	
B5200	PARNTRL NUT AMINO ACID & CARS STRSS	Prior authorization is required when the billed charges are greater than \$500.	
B9002	ENTERAL NUTR INFUSION PUMP ANY TYPE	Prior authorization is required when the billed charges are greater than \$500.	
B9004	PARNTRAL NUTRIT INFUS PUMP PRTBLE	Prior authorization is required when the billed charges are greater than \$500.	
B9006	PARNTRAL NUTRIT INFUS PUMP STATION	Prior authorization is required when the billed charges are greater than \$500.	
B9998	NOC FOR ENTERAL SUPPLIES	Prior authorization is required when the billed charges are greater than \$500.	
B9999	NOC FOR PARENTERAL SUPPLIES	Prior authorization is required when the billed charges are greater than \$500.	
C1725	Catheter, transluminal angioplasty, nonlaser (may include guidance, infusion/perfusion capability)	Prior authorization is required.	
C1789	Prosthesis, breast (implantable)	Prior authorization is required and medical necessity criteria must be met. Cosmetic procedures	
		are a non-covered service.	
C1874	Stent, coated/covered, with delivery system	Prior authorization is required.	
C1876	Stent, noncoated/noncovered, with delivery system	Prior authorization is required.	
C1885	Catheter, transluminal angioplasty, laser	Prior authorization is required.	
C1889	Implantable/insertable device, not otherwise classified	Prior authorization is required for billed charges greater than \$500.	
C2625	Stent, noncoronary, temporary, with delivery system	Prior authorization is required.	
C7903	Group psychotherapy service for diagnosis, evaluation, or treatment of a mental health or substance use disorder provided remotely by hospital staff who are licensed to provide mental health services under applicable state law(s), when the patient is in		
C8900	MRA Abdomen with contrast	Prior authorization is managed by EviCore.	Prior authorization is managed by EviCore.
C8901	MRA Abdomen without contrast	Prior authorization is managed by EviCore.	Prior authorization is managed by EviCore.
C8902	MRA Abdomen with and w/o contrast	Prior authorization is managed by EviCore.	Prior authorization is managed by EviCore.
C8903	MRI Breast w/ contrast, unilateral	Prior authorization is managed by EviCore.	Prior authorization is managed by EviCore.
C8904	MRI Breast w/o contrast, unilateral	Prior authorization is required.	
C8905	MRI Breast w. and w/o contrast, unilateral	Prior authorization is managed by EviCore.	Prior authorization is managed by EviCore.
C8906	MRI Breast Bilateral W/ Contrast	Prior authorization is managed by EviCore.	Prior authorization is managed by EviCore.
C8907	MRI Breast Bilateral W/O Contrast	Prior authorization is required.	
C8908	MRI Breast Bilateral W/ And W/O Contrast	Prior authorization is managed by EviCore.	Prior authorization is managed by EviCore.
C8909	MRA chest w/contrast (excluding myocardium)	Prior authorization is managed by EviCore.	Prior authorization is managed by EviCore.
C8910	MRA chest w/o contrast (excluding myocardium)	Prior authorization is managed by EviCore.	Prior authorization is managed by EviCore.
C8911	MRA chest w/ and w/o contrast (excluding myocardium)	Prior authorization is managed by EviCore.	Prior authorization is managed by EviCore.
C8912	MRA lower extremity w/ contrast	Prior authorization is managed by EviCore.	Prior authorization is managed by EviCore.
C8913	MRA lower extremity w/o contrast	Prior authorization is managed by EviCore.	Prior authorization is managed by EviCore.
C8914	MRA lower extremity w/ and w/o contrast	Prior authorization is managed by EviCore.	Prior authorization is managed by EviCore.
C8918	MRA pelvis w/ contrast	Prior authorization is managed by EviCore.	Prior authorization is managed by EviCore.
C8919	MRA pelvis w/o contrast	Prior authorization is managed by EviCore.	Prior authorization is managed by EviCore.
			Prior authorization is managed by

C8921	Transthoracic echocardiography w/contrast for congenital cardiac anomalies; complete	Prior authorization is managed by EviCore.	Prior authorization is managed b EviCore.
C8922	Transthoracic echocardiography w/contrast for congenital cardiac anomalies; f/u or limited study	Prior authorization is managed by EviCore.	Prior authorization is managed b EviCore.
C8923	Transthoracic echocardiography w/contrast, real-time w/image documentation (2d), w/wo m-mode recording; complete	Prior authorization is managed by EviCore.	Prior authorization is managed b EviCore.
C8924	Transthoracic echocardiography w/contrast, real-time w/image documentation (2d), w/wo m-mode recording; f/u or limited study	Prior authorization is managed by EviCore.	Prior authorization is managed b EviCore.
C8925	Transesophageal echocardiography (TEE) with contrast, or without contrast followed by with contrast, real time with image documentation (2D) (with or without M-mode recording); including probe placement, image acquisition, interpretation and report	Prior authorization is managed by EviCore.	Prior authorization is managed b EviCore.
C8926	Transesophageal echocardiography (TEE) with contrast, or without contrast followed by with contrast, for congenital cardiac anomalies; including probe placement, image acquisition, interpretation and report	Prior authorization is managed by EviCore.	Prior authorization is managed b EviCore.
C8928	Transthoracic echocardiography w/contrast, real-time w/image documentation (2d), w/wo m-mode recording, during rest and cardiovascular stress test, w/interpretation and report	Prior authorization is managed by EviCore.	Prior authorization is managed b EviCore.
C8929	Transthoracic echocardiography with contrast, or without contrast followed by with contrast, real-time with image documentation (2d), includes m-mode recording, when performed, complete, with spectral doppler echocardiography and with color flow doppler echocardiography	Prior authorization is managed by EviCore.	Prior authorization is managed t EviCore.
C8930	Transthoracic echocardiography, with contrast, or without contrast followed by with contrast, real-time with image documentation (2d), includes m-mode recording, when performed, during rest and cardiovascular stress test using treadmill, bicycle exercise and/or pharmacologically induced stress, with interpretation and report, including performance of continuous electrocardiographic monitoring, with physician supervision	Prior authorization is managed by EviCore.	Prior authorization is managed t EviCore.
C8931	MRA, W/ Dye, Spinal Canal	Prior authorization is managed by EviCore.	Prior authorization is managed b EviCore.
C8932	MRA, W/O Dye, Spinal Canal	Prior authorization is managed by EviCore.	Prior authorization is managed b EviCore.
C8933	MRA, W/O & W/ Dye, Spinal Canal	Prior authorization is managed by EviCore.	Prior authorization is managed b EviCore.
C8934	MRA, W/ Dye, Upper Extremity	Prior authorization is managed by EviCore.	Prior authorization is managed b EviCore.
C8935	MRA, W/O Dye, Upper Extr	Prior authorization is managed by EviCore.	Prior authorization is managed b EviCore.
C8936	MRA, W/O & W/ Dye, Upper Extr	Prior authorization is managed by EviCore.	Prior authorization is managed I EviCore.
C9727	Insertion of implants into the soft palate; minimum of three implants	Prior authorization is required. Reference policies for additional information. HHO-DE-MP-1064 Diagnosis and Treatment of Obstructive Sleep Apnea in Adults	
	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial		
C9757	facetectomy, foraminotomy and excision of herniated intervertebral disc and repair of annular defect with implantation of bone anchored annular closure device, including annular defect measurement, alignment and sizing assessment and image guidance; 1 interspace, lumbar	Prior authorization is managed by EviCore.	Prior authorization is managed I EviCore.
C9757 C9762 *	annular defect with implantation of bone anchored annular closure device, including annular defect measurement, alignment and sizing assessment and image guidance; 1	Prior authorization is managed by EviCore. Prior authorization is managed by EviCore.	EviCore.
	annular defect with implantation of bone anchored annular closure device, including annular defect measurement, alignment and sizing assessment and image guidance; 1 interspace, lumbar Cardiac magnetic resonance imaging for morphology and function, quantification of segmental dysfunction; with		EviCore. Prior authorization is managed t EviCore.
C9762 *	annular defect with implantation of bone anchored annular closure device, including annular defect measurement, alignment and sizing assessment and image guidance; 1 interspace, lumbar Cardiac magnetic resonance imaging for morphology and function, quantification of segmental dysfunction; with strain imaging Cardiac magnetic resonance imaging for morphology and function, quantification of	Prior authorization is managed by EviCore.	Prior authorization is managed b EviCore. Prior authorization is managed b
C9762 * C9763 *	annular defect with implantation of bone anchored annular closure device, including annular defect measurement, alignment and sizing assessment and image guidance; 1 interspace, lumbar Cardiac magnetic resonance imaging for morphology and function, quantification of segmental dysfunction; with strain imaging Cardiac magnetic resonance imaging for morphology and function, quantification of segmental dysfunction; with stress imaging Magnetic resonance imaging for morphology and function, quantification of segmental dysfunction; with stress imaging Magnetic resonance imaging with inhaled hyperpolarized xenon-129 contrast agent, chest, including preparation and administration of agent 3d predictive model generation for pre-planning of a cardiac procedure, using data from	Prior authorization is managed by EviCore. Prior authorization is managed by EviCore.	EviCore. Prior authorization is managed t EviCore. Prior authorization is managed t EviCore. Prior authorization is managed t
C9762 * C9763 * C9791	annular defect with implantation of bone anchored annular closure device, including annular defect messurement, alignment and sizing assessment and image guidance; 1 interspace, lumbar Cardiac magnetic resonance imaging for morphology and function, quantification of segmental dysfunction; with strain imaging Cardiac magnetic resonance imaging for morphology and function, quantification of segmental dysfunction; with stress imaging Magnetic resonance imaging with inhaled hyperpolarized xenon-129 contrast agent, chest, including preparation and administration of agent	Prior authorization is managed by EviCore. Prior authorization is managed by EviCore.	EviCore. Prior authorization is managed EviCore. Prior authorization is managed EviCore. Prior authorization is managed
C9762 * C9763 * C9791 C9793 C9795 D0120	annular defect with implantation of bone anchored annular closure device, including annular defect messurement, alignment and sizing assessment and image guidance; 1 interspace, lumbar Cardiac magnetic resonance imaging for morphology and function, quantification of segmental dysfunction; with strain imaging Cardiac magnetic resonance imaging for morphology and function, quantification of segmental dysfunction; with stress imaging Magnetic resonance imaging for morphology and function, quantification of segmental dysfunction; with stress imaging Magnetic resonance imaging with inhaled hyperpolarized venon-129 contrast agent, chest, including preparation and administration of agent 3d predictive model generation for pre-planning of a cardiac procedure, using data from cardiac computed tomographic angiography with report Stereotactic body radiation therapy, treatment delivery, per fraction to 1 or more lesions, including image guidance and real-time positron emissions-based delivery adjustments to 1 or more lesions, entire course not to exceed 5 fractions PERIODIC DRAL EVALUATION	Prior authorization is managed by EviCore. Coverage is managed by United Concordia Dental	EviCore. Prior authorization is managed EviCore. Prior authorization is managed EviCore. Prior authorization is managed
C9762 * C9763 * C9791 C9793 C9795 D0120 D0140	annular defect with implantation of bone anchored annular closure device, including annular defect measurement, alignment and sizing assessment and image guidance; 1 interspace, lumbar Cardiac magnetic resonance imaging for morphology and function, quantification of segmental dysfunction; with Strain imaging Cardiac magnetic resonance imaging for morphology and function, quantification of segmental dysfunction; with stress imaging Magnetic resonance imaging for morphology and function, quantification of segmental dysfunction; with stress imaging Magnetic resonance imaging with inhaled hyperpolarized xenon-129 contrast agent, chest, including preparation and administration of agent 3d predictive model generation for pre-planning of a cardiac procedure, using data from cardiac computed tomographic angiography with report Stereotactic body radiation therapy, treatment delivery, per fraction to 1 or more lesions, including image guidance and real-time positron emissions-based delivery adjustments to 1 or more lesions, entire course not to exceed 5 fractions PERIODIC ORAL EVALUATION LIMIT ORAL EVAL PROBLM FOCUS	Prior authorization is managed by EviCore. Prior authorization is managed by EviCore. Prior authorization is managed by EviCore. Coverage is managed by United Concordia Dental Coverage is managed by United Concordia Dental	EviCore. Prior authorization is managed EviCore. Prior authorization is managed EviCore. Prior authorization is managed
C9762 * C9763 * C9791 C9793 C9795 D0120 D0140 D0150	annular defect with implantation of bone anchored annular closure device, including annular defect measurement, alignment and sizing assessment and image guidance; 1 interspace, lumbar Cardiac magnetic resonance imaging for morphology and function, quantification of segmental dysfunction; with strain imaging Cardiac magnetic resonance imaging for morphology and function, quantification of segmental dysfunction; with strain imaging Magnetic resonance imaging for morphology and function, quantification of segmental dysfunction; with stress imaging Magnetic resonance imaging for morphology and function, quantification of segmental dysfunction; with stress imaging Magnetic resonance imaging for morphology and function, quantification of segmental dysfunction; with stress imaging Magnetic resonance imaging for morphology and function of agent 3d predictive model generation for pre-planning of a cardiac procedure, using data from cardiac computed tomographic angiography with report Stereotactic body radiation therapy, treatment delivery, per fraction to 1 or more lesions, including image guidance and real-time positron emissions-based delivery adjustments to 1 or more lesions, entire course not to exceed 5 fractions PERIODIC ORAL EVALUATION UIMIT ORAL EVAL PROBLM FOCUS COMPREHENSVE ORAL EVALUATION	Prior authorization is managed by EviCore. Coverage is managed by United Concordia Dental	EviCore. Prior authorization is managed EviCore. Prior authorization is managed EviCore. Prior authorization is managed
C9762 * C9763 * C9791 C9793 C9795 D0120 D0140 D0150 D0160	annular defect with implantation of bone anchored annular dosure device, including annular defect messurement, alignment and sizing assessment and image guidance; 1 interspace, lumbar Cardiac magnetic resonance imaging for morphology and function, quantification of segmental dysfunction; with strain imaging Cardiac magnetic resonance imaging for morphology and function, quantification of segmental dysfunction; with stress imaging Magnetic resonance imaging with inhaled hyperpolarized xenon-129 contrast agent, chest, including preparation and administration of agent 3d predictive model generation for pre-planning of a cardiac procedure, using data from cardiac computed tomographic angiography with report Stereotactic body radiation therapy, treatment delivery, per fraction to 1 or more lesions, including image guidance and real-time positron emissions-based delivery adjustments to 1 or more lesions, entire course not to exceed 5 fractions PERIODIC ORAL EVAL PROB.M FOCUS	Prior authorization is managed by EviCore. Coverage is managed by United Concordia Dental	EviCore. Prior authorization is managed EviCore. Prior authorization is managed EviCore. Prior authorization is managed
C9762 * C9763 * C9791 C9793 C9795 D0120 D0140 D0150 D0160 D0170	annular defect with implantation of bone anchored annular closure device, including annular defect messurement, alignment and sizing assessment and image guidance; 1 interspace, lumbar Cardiac magnetic resonance imaging for morphology and function, quantification of segmental dysfunction; with strain imaging Cardiac magnetic resonance imaging for morphology and function, quantification of segmental dysfunction; with stress imaging Magnetic resonance imaging for morphology and function, quantification of segmental dysfunction; with stress imaging Magnetic resonance imaging morphology and function, quantification of segmental dysfunction; with stress imaging during preparation and administration of agent 3d predictive model generation for pre-planning of a cardiac procedure, using data from cardiac computed tomographic angiography with report Stereotactic body radiation therapy, treatment delivery, per fraction to 1 or more lesions, including image guidance and real-time positron emissions-based delivery adjustments to 1 or more lesions, entire course not to exceed 5 fractions PERIODIC ORAL EVALLIVATION LIMIT ORAL EVAL PROBLM FOCUS COMPREHENSYE ORAL EVALUATION EXTENSY ORAL EVAL PROBLM FOCUS RE-EVAL,EST PT, PROBLEM FOCUS	Prior authorization is managed by EviCore. Prior authorization is managed by EviCore. Prior authorization is managed by EviCore. Coverage is managed by United Concordia Dental	EviCore. Prior authorization is managed EviCore. Prior authorization is managed EviCore. Prior authorization is managed
C9762 * C9763 * C9791 C9793 C9795 D0120 D0140 D0150 D0160 D0170 D0180	annular defect with implantation of bone anchored annular closure device, including annular defect measurement, alignment and sizing assessment and image guidance; 1 interspace, lumbar Cardiac magnetic resonance imaging for morphology and function, quantification of segmental dysfunction; with Strain imaging Cardiac magnetic resonance imaging for morphology and function, quantification of segmental dysfunction; with stress imaging Magnetic resonance imaging for morphology and function, quantification of segmental dysfunction; with stress imaging Magnetic resonance imaging for morphology and function, quantification of segmental dysfunction; with stress imaging 3d predictive model generation and administration of agent 3d predictive model generation for pre-planning of a cardiac procedure, using data from cardiac computed tomographic angiography with report Stereotactic body radiation therapy, treatment delivery, per fraction to 1 or more lesions, including image guidance and real-time positron emissions-based delivery adjustments to 1 or more lesions, entire course not to exceed 5 fractions PERIODIC ORAL EVALIDATION LIMIT ORAL EVAL PROBLM FOCUS COMPREHENSVE ORAL EVALIDATION EXTENSV ORAL EVALIDATION RE-EVALEST PT PROBLEM FOCUS	Prior authorization is managed by EviCore. Coverage is managed by United Concordia Dental	EviCore. Prior authorization is managed EviCore. Prior authorization is managed EviCore. Prior authorization is managed
C9762 * C9763 * C9791 C9793 C9795 D0120 D0140 D0150 D0160 D0170 D0180 D0180 D0210	annular defect with implantation of bone anchored annular dosure device, including annular defect mesurement, alignment and sizing assessment and image guidance; 1 interspace, lumbar Cardiac magnetic resonance imaging for morphology and function, quantification of segmental dysfunction; with strain imaging Cardiac magnetic resonance imaging for morphology and function, quantification of segmental dysfunction; with stress imaging Magnetic resonance imaging for morphology and function, quantification of segmental dysfunction; with stress imaging dysfunction; with stress imaging for morphology and function, quantification of segmental dysfunction; with stress imaging dysfunction; with stress imaging for morphology and function, quantification of agent including preparation and administration of agent 3d predictive model generation for pre-planning of a cardiac procedure, using data from cardiac computed tomographic angiography with report Stereotactic body radiation therapy, treatment delivery, per fraction to 1 or more lesions, including image guidance and real-time positron emissions-based delivery adjustments to 1 or more lesions, entire course not to exceed 5 fractions PERIODIC ORAL EVALUATION LIMIT ORAL EVAL PROBLY FOCUS COMPREHENSV CARL EVALUATION EXTENSV ORAL EVAL PROB FOCUS RE-EVAL,EST PT_PROBLEM FOCUS COMP PERIODONTAL EVALUATION INTRAOR COMPLETE FILM SERIES	Prior authorization is managed by EviCore. Coverage is managed by United Concordia Dental	EviCore. Prior authorization is managed EviCore. Prior authorization is managed EviCore. Prior authorization is managed
C9762 * C9763 * C9791 C9793 C9795 D0120 D0140 D0150 D0160 D0170 D0180 D0210 D0220	annular defect with implantation of bone anchored annular dosure device, including annular defect messurement, alignment and sizing assessment and image guidance; 1 interspace, lumbar Cardiac magnetic resonance imaging for morphology and function, quantification of segmental dysfunction; with strain imaging Cardiac magnetic resonance imaging for morphology and function, quantification of segmental dysfunction; with stress imaging Magnetic resonance imaging with inhaled hyperpolarized xenon-129 contrast agent, chest, including preparation and administration of agent 3d predictive model generation for pre-planning of a cardiac procedure, using data from cardiac computed tomographic angiography with report Stereotactic body radiation therapy, treatment delivery, per fraction to 1 or more lesions, including image guidance and real-time positron emissions-based delivery adjustments to 1 or more lesions, entire course not to exceed 5 fractions PERIODIC ORAL EVAL PROBLEM FOCUS COMPREHENSVE ORAL EVALUATION LUMIT ORAL EVAL PROBLEM FOCUS RE-EVALEST PT_PROBLEM FOCUS COM PERIODONTAL EVALUATION INTRAOR COMPLET FLIM SERIES INTRAORAL PERIAPICAL FIRST	Prior authorization is managed by EviCore. Coverage is managed by United Concordia Dental	EviCore. Prior authorization is managed EviCore. Prior authorization is managed EviCore. Prior authorization is managed
C9762 * C9763 * C9791 C9793 C9795 D0120 D0140 D0150 D0150 D0170 D0180 D0210 D0220 D0230	annular defect with implantation of bone anchored annular closure device, including annular defect messurement, alignment and sizing assessment and image guidance; 1 interspace, lumbar Cardiac magnetic resonance imaging for morphology and function, quantification of segmental dysfunction; with strain imaging Cardiac magnetic resonance imaging for morphology and function, quantification of segmental dysfunction; with stress imaging Magnetic resonance imaging for morphology and function, quantification of segmental dysfunction; with stress imaging Magnetic resonance imaging for morphology and function, quantification of segmental dysfunction; with stress imaging Streit cresonance imaging for morphology and function, quantification of segmental dysfunction; with stress imaging Magnetic resonance imaging for morphology and function, quantification of segmental dysfunction; with stress imaging Streit cresonance imaging for morphology and function, quantification of a gent cresonance imaging for morphology and function, quantification of segmental dysfunction; with stress imaging Stereotactic body radiation therapy, treatment delivery, per fraction to 1 or more lesions, including image guidance and real-time positron emissions-based delivery adjustments to 1 or more lesions, entire course not to exceed 5 fractions PERIODIC ORAL EVALLYION LIMIT ORAL EVAL PROBLEW FOCUS COMPRETENSVE ORAL EVALUATION EXTENSV ORAL EVALLATION EXTENSV ORAL EVALLATION INTRAORAL PERIAPICAL ENDEST INTRAORAL PERIAPICAL FIRST INTRAORAL PERIAPICAL FIRST	Prior authorization is managed by EviCore. Prior authorization is managed by EviCore. Prior authorization is managed by EviCore. Coverage is managed by United Concordia Dental	EviCore. Prior authorization is managed EviCore. Prior authorization is managed EviCore. Prior authorization is managed
C9762 * C9763 * C9791 C9793 C9795 D0120 D0140 D0150 D0160 D0170 D0180 D0210 D0220 D0220 D0230 D0272	annular defect with implantation of bone anchored annular dosure device, including annular defect mesurement, alignment and sizing assessment and image guidance; 1 interspace, lumbar Cardiac magnetic resonance imaging for morphology and function, quantification of segmental dysfunction; with strain imaging Cardiac magnetic resonance imaging for morphology and function, quantification of segmental dysfunction; with stress imaging Magnetic resonance imaging for morphology and function, quantification of segmental dysfunction; with stress imaging Magnetic resonance imaging with inhaled hyperpolarized xenon-129 contrast agent, chest, including preparation and administration of agent 3d predictive model generation for pre-planing of a cardiac procedure, using data from cardiac computed tomographic angiography with report Stereotactic body radiation therapy, treatment delivery, per fraction to 1 or more lesions, including image guidance and real-time positron emissions-based delivery adjustments to 1 or more lesions, entire course not to exceed 5 fractions PERIODIC ORAL EVALUATION LIMIT ORAL EVAL PROBEM FOCUS COMPREHENSV CORAL EVALUATION EXTENSV ORAL EVAL PROBE FOCUS RE-EVALEST PT_PROBELEM FOCUS COMP PERIOPONTAL EVALUATION INTRAOR COMPLETE FILM SERIES INTRAORAL PERIAPICAL FIRST INTRAORAL PERIAPICAL FIRST DENTAL BITEWINGS TWO IMAGES	Prior authorization is managed by EviCore. Prior authorization is managed by EviCore. Prior authorization is managed by EviCore. Coverage is managed by United Concordia Dental Co	EviCore. Prior authorization is managed EviCore. Prior authorization is managed EviCore. Prior authorization is managed
C9762 * C9763 * C9791 C9793 C9795 D0120 D0140 D0150 D0160 D0170 D0180 D0210 D0220 D0220 D0230 D0272 D0274	annular defect with implantation of bone anchored annular dosure device, including annular defect messurement, alignment and sizing assessment and image guidance; 1 interspace, lumbar Cardiac magnetic resonance imaging for morphology and function, quantification of segmental dysfunction; with strain imaging Cardiac magnetic resonance imaging for morphology and function, quantification of segmental dysfunction; with stress imaging Magnetic resonance imaging with inhaled hyperpolarized xenon-129 contrast agent, chest, including preparation and administration of agent 3d predictive model generation for pre-planning of a cardiac procedure, using data from cardiac computed tomographic angiography with report Stereotactic body radiation therapy, treatment delivery, per fraction to 1 or more lesions, including image guidance and real-time positron emissions-based delivery adjustments to 1 or more lesions, entire course not to exceede 5 fractions PERIODIC ORAL EVAL PROBLY FOCUS COMPREHENSVE ORAL EVALUATION EXTENSV ORAL EVAL PROBLY FOCUS COMPREHENSVE ORAL EVALUATION EXTENSV ORAL EVAL PROBLY FOCUS COMP PERIODONTAL EVALUATION INTRAORAL PERIAPICAL ERAIL INTRAORAL PERIAPICAL EARD INTRAORAL PERIAPICAL EARD DENTAL BITEWINGS TWO IMAGES	Prior authorization is managed by EviCore. Prior authorization is managed by EviCore. Prior authorization is managed by EviCore. Coverage is managed by United Concordia Dental Coverage is managed by United Concordia Dental Ental Coverage is managed by United Concordia Dental <	EviCore. Prior authorization is managed EviCore. Prior authorization is managed EviCore. Prior authorization is managed
C9762 * C9763 * C9791 C9793 C9795 D0120 D0140 D0150 D0160 D0170 D0180 D0210 D0220 D0220 D0230 D0272	annular defect with implantation of bone anchored annular dosure device, including annular defect mesurement, alignment and sizing assessment and image guidance; 1 interspace, lumbar Cardiac magnetic resonance imaging for morphology and function, quantification of segmental dysfunction; with strain imaging Cardiac magnetic resonance imaging for morphology and function, quantification of segmental dysfunction; with stress imaging Magnetic resonance imaging for morphology and function, quantification of segmental dysfunction; with stress imaging Magnetic resonance imaging with inhaled hyperpolarized xenon-129 contrast agent, chest, including preparation and administration of agent 3d predictive model generation for pre-planing of a cardiac procedure, using data from cardiac computed tomographic angiography with report Stereotactic body radiation therapy, treatment delivery, per fraction to 1 or more lesions, including image guidance and real-time positron emissions-based delivery adjustments to 1 or more lesions, entire course not to exceed 5 fractions PERIODIC ORAL EVALUATION LIMIT ORAL EVAL PROBEM FOCUS COMPREHENSV CORAL EVALUATION EXTENSV ORAL EVAL PROBE FOCUS RE-EVALEST PT_PROBELEM FOCUS COMP PERIOPONTAL EVALUATION INTRAOR COMPLETE FILM SERIES INTRAORAL PERIAPICAL FIRST INTRAORAL PERIAPICAL FIRST DENTAL BITEWINGS TWO IMAGES	Prior authorization is managed by EviCore. Prior authorization is managed by EviCore. Prior authorization is managed by EviCore. Coverage is managed by United Concordia Dental Co	EviCore. Prior authorization is managed EviCore. Prior authorization is managed EviCore. Prior authorization is managed

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

E0156	SEAT ATTACHMENT WALKER	Prior authorization is required when the billed charges are greater than \$500.		
E0157	CRUTCH ATTACHMENT WALKER EACH	Prior authorization is required when the billed charges are greater than \$500.		
E0158	LEG EXTENSIONS WALKER PER SET FOUR	Prior authorization is required when the billed charges are greater than \$500.		
E0159	BRAKE ATTCH WHEELED WALK REPLCMT EA	Prior authorization is required when the billed charges are greater than \$500.		
E0160	SITZ BATH/EQP PRTBLE W/WO COMMODE	Prior authorization is required when the billed charges are greater than \$500.		
E0161	SITZ BATH/EQP PRTBLE USED W/FAUCET	Prior authorization is required when the billed charges are greater than \$500.		
E0162	SITZ BATH CHAIR	Prior authorization is required when the billed charges are greater than \$500.		
E0163	COMMODE CHAIR WITH FIXED ARMS	Prior authorization is required when the billed charges are greater than \$500.		
E0165	COMMODE CHAIR WITH DETACHABLE ARMS	Prior authorization is required when the billed charges are greater than \$500.		
E0167	PAIL/PAN USE W/COMMODE CHAIR REPL	Prior authorization is required when the billed charges are greater than \$500.		
E0168	COMMODE CHAIR XTRA WIDE&/HEVY DUTY	Prior authorization is required when the billed charges are greater than \$500.		
E0170	COMMODE CHAIR SEAT LIFT MECH ELEC	Prior authorization is required when the billed charges are greater than \$500.		
E0171	COMMODE CHAIR SEAT LIFT MCH NONELEC	Prior authorization is required when the billed charges are greater than \$500.		
E0172	SEAT LIFT MECH PLACE OVR/TOP TOILET	Prior authorization is required when the billed charges are greater than \$500.		
E0175	FOOT REST USE W/COMMODE CHAIR EACH	Prior authorization is required when the billed charges are greater than \$500.		
E0181	Powered pressure reducing mattress overlay/pad, alternating, with pump, includes heavy- duty	Prior authorization is required for billed charges greater than \$500. Reference policies for additional information.	HHO-DE-MP-1183 Beds, Accessories and Related Items	
E0182	PUMP ALTERNATING PRESSURE PAD REPL	Prior authorization is required when the billed charges are greater than \$500.		
E0183	PWR PRESS RDUC UNDRLAY/PAD ALT PUMP	Prior authorization is required when the billed charges are greater than \$500.		
E0184	Dry pressure mattress	Prior authorization is required for billed charges greater than \$500. Reference policies for	HHO-DE-MP-1183 Beds, Accessories and Related Items	
		additional information. Prior authorization is required for billed charges greater than \$500. Reference policies for		
E0185	Gel or gel-like pressure pad for mattress, standard mattress length and width	additional information. Prior authorization is required for billed charges greater than \$500. Reference policies for	HHO-DE-MP-1183 Beds, Accessories and Related Items	
E0186	Air pressure mattress	additional information. Prior authorization is required for billed charges greater than \$500. Reference policies for	HHO-DE-MP-1183 Beds, Accessories and Related Items	
E0187	Water pressure mattress	additional information.	HHO-DE-MP-1183 Beds, Accessories and Related Items	
E0188	SYNTHETIC SHEEPSKIN PAD	Prior authorization is required when the billed charges are greater than \$500.		
E0189	LAMBSWOOL SHEEPSKIN PAD ANY SIZE	Prior authorization is required when the billed charges are greater than \$500.		
E0190	PSTN CUSH/PILLOW/EDGE ALL COMPONENT	Prior authorization is required when the billed charges are greater than \$500.		4
E0191	HEEL OR ELBOW PROTECTOR EACH	Prior authorization is required when the billed charges are greater than \$500.		
E0193	Powered air flotation bed (low air loss therapy)	Prior authorization is required for billed charges greater than \$500. Reference policies for additional information.	HHO-DE-MP-1183 Beds, Accessories and Related Items	
E0194	Air fluidized bed	Prior authorization is required for billed charges greater than \$500. Reference policies for additional information.	HHO-DE-MP-1183 Beds, Accessories and Related Items	
E0196	Gel pressure mattress	Prior authorization is required for billed charges greater than \$500. Reference policies for additional information.	HHO-DE-MP-1183 Beds, Accessories and Related Items	
E0197	Air pressure pad for mattress, standard mattress length and width	Prior authorization is required for billed charges greater than \$500. Reference policies for additional information.	HHO-DE-MP-1183 Beds, Accessories and Related Items	
E0198	Water pressure pad for mattress, standard mattress length and width	Prior authorization is required for billed charges greater than \$500. Reference policies for additional information.	HHO-DE-MP-1183 Beds, Accessories and Related Items	
E0199	Dry pressure pad for mattress, standard mattress length and width	Prior authorization is required for billed charges greater than \$500. Reference policies for additional information.	HHO-DE-MP-1183 Beds, Accessories and Related Items	
E0200	HEAT LAMP W/O STAND W/INFRARD ELEM	Prior authorization is required when the billed charges are greater than \$500.		ł
E0202	PHOTOTHERAPY LIGHT WITH PHOTOMETER	Prior authorization is required when the billed charges are greater than \$500.		t
E0203	TX LTBOX MINI 10000 LUX TABLE TOP	Prior authorization is required when the billed charges are greater than \$500.		t
E0205	HEAT LAMP W/STAND W/INFRARD ELEM	Prior authorization is required when the billed charges are greater than \$500.		t
E0210	ELECTRIC HEAT PAD STANDARD	Prior authorization is required for billed charges greater than \$500. Reference policies for additional information.	HHO-DE-MP-1246 Home Dialysis Equipment and Supplies	
E0215	ELECTRIC HEAT PAD MOIST	Prior authorization is required when the billed charges are greater than \$500.		t
E0215	WATER CIRCULATING HEAT PAD W/PUMP	Prior authorization is required when the billed charges are greater than \$500.		
E0218	FLUID CIRC COLD PAD W/PUMP ANY TYPE	Prior authorization is required when the billed charges are greater than \$500.		1
E0221	INFRARED HEATING PAD SYSTEM	Prior authorization is required when the billed charges are greater than \$500.		1
E0225	HYDROCOLLATOR UNIT INCLUDES PADS	Prior authorization is required when the billed charges are greater than \$500.		<u> </u>
E0231	NON-CNTC WND WARM DEVC W/CARD&COVR	Prior authorization is required when the billed charges are greater than \$500.		1
E0232	WOUND WARMING WOUND COVER	Prior authorization is required when the billed charges are greater than \$500.		1
E0235	PARAFFIN BATH UNIT PORTABLE	Prior authorization is required when the billed charges are greater than \$500.		t
E0236	PUMP FOR WATER CIRCULATING PAD	Prior authorization is required when the billed charges are greater than \$500.		t
E0239	HYDROCOLLATOR UNIT PORTABLE	Prior authorization is required when the billed charges are greater than \$500.		t
E0240	BATH/SHOWER CHAIR W/WO WHLS ANY SZ	Prior authorization is required when the billed charges are greater than \$500.		t
E0241	BATHTUB WALL RAIL EACH	Prior authorization is required when the billed charges are greater than \$500.		t
E0242	BATHTUB RAIL FLOOR BASE	Prior authorization is required when the billed charges are greater than \$500.		t
E0243				t
	TOILET RAIL EACH	Prior authorization is required when the billed charges are greater than \$500.		
E0244	TOILET RAIL EACH RAISED TOILET SEAT	Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500.		
	RAISED TOILET SEAT	Prior authorization is required when the billed charges are greater than \$500.		
E0244 E0245 E0246				
E0245	RAISED TOILET SEAT TUB STOOL OR BENCH TRANSFER TUB RAIL ATTACHMENT	Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500.		
E0245 E0246	RAISED TOILET SEAT TUB STOOL OR BENCH	Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500.		

E0250	Hospital bed, fixed height, with any type side rails, with mattress	Prior authorization is required for billed charges greater than \$500. Reference policies for additional information.	HHO-DE-MP-1183 Beds, Accessories and Related Items
E0251	Hospital bed, fixed height, with any type side rails, without mattress	Prior authorization is required for billed charges greater than \$500. Reference policies for additional information.	HHO-DE-MP-1183 Beds, Accessories and Related Items
E0255	Hospital bed, variable height, hi-lo, with any type side rails, with mattress	Prior authorization is required for billed charges greater than \$500. Reference policies for additional information.	HHO-DE-MP-1183 Beds, Accessories and Related Items
E0256	Hospital bed, variable height, hi-lo, with any type side rails, without mattress	Prior authorization is required for billed charges greater than \$500. Reference policies for additional information.	HHO-DE-MP-1183 Beds, Accessories and Related Items
E0260	Hospital bed, semi-electric (head and foot adjustment), with any type side rails, with mattress	Prior authorization is required for billed charges greater than \$500. Reference policies for additional information.	HHO-DE-MP-1183 Beds, Accessories and Related Items
E0261	Hospital bed, semi-electric (head and foot adjustment), with any type side rails, without mattress	Prior authorization is required for billed charges greater than \$500. Reference policies for additional information.	HHO-DE-MP-1183 Beds, Accessories and Related Items
E0265	Hospital bed, total electric (head, foot and height adjustments), with any type side rails, with mattress	Prior authorization is required for billed charges greater than \$500. Reference policies for additional information.	HHO-DE-MP-1183 Beds, Accessories and Related Items
E0266	Hospital bed, total electric (head, foot and height adjustments), with any type side rails, without mattress	Prior authorization is required for billed charges greater than \$500. Reference policies for additional information.	HHO-DE-MP-1183 Beds, Accessories and Related Items
E0270	HOSP BED INST TYPE: W/MATTRSS	Prior authorization is required when the billed charges are greater than \$500.	
E0271	Mattress, innerspring	Prior authorization is required for billed charges greater than \$500. Reference policies for additional information.	HHO-DE-MP-1183 Beds, Accessories and Related Items
E0272	Mattress, foam rubber	Prior authorization is required for billed charges greater than \$500. Reference policies for additional information.	HHO-DE-MP-1183 Beds, Accessories and Related Items
E0273	Bed board	Prior authorization is required for billed charges greater than \$500. Reference policies for additional information.	HHO-DE-MP-1183 Beds, Accessories and Related Items
E0274	Over-bed table	Prior authorization is required for billed charges greater than \$500. Reference policies for additional information.	HHO-DE-MP-1183 Beds, Accessories and Related Items
E0275	Bed pan, standard, metal or plastic	Prior authorization is required for billed charges greater than \$500. Reference policies for additional information.	HHO-DE-MP-1183 Beds, Accessories and Related Items
E0276	Bed pan, fracture, metal or plastic	Prior authorization is required for billed charges greater than \$500. Reference policies for additional information.	HHO-DE-MP-1183 Beds, Accessories and Related Items
E0277	Powered pressure-reducing air mattress	Prior authorization is required for billed charges greater than \$500. Reference policies for additional information.	HHO-DE-MP-1183 Beds, Accessories and Related Items
E0280	Bed cradle, any type	Prior authorization is required for billed charges greater than \$500. Reference policies for additional information.	HHO-DE-MP-1183 Beds, Accessories and Related Items
E0290	Hospital bed, fixed height, without side rails, with mattress	Prior authorization is required for billed charges greater than \$500. Reference policies for additional information.	HHO-DE-MP-1183 Beds, Accessories and Related Items
E0291	Hospital bed, fixed height, without side rails, without mattress	Prior authorization is required for billed charges greater than \$500. Reference policies for additional information.	HHO-DE-MP-1183 Beds, Accessories and Related Items
E0292	Hospital bed, variable height, hi-lo, without side rails, with mattress	Prior authorization is required for billed charges greater than \$500. Reference policies for additional information.	HHO-DE-MP-1183 Beds, Accessories and Related Items
E0293	Hospital bed, variable height, hi-lo, without side rails, without mattress	Prior authorization is required for billed charges greater than \$500. Reference policies for additional information.	HHO-DE-MP-1183 Beds, Accessories and Related Items
E0294	Hospital bed, semi-electric (head and foot adjustment), without side rails, with mattress	Prior authorization is required for billed charges greater than \$500. Reference policies for additional information.	HHO-DE-MP-1183 Beds, Accessories and Related Items
E0295	Hospital bed, semi-electric (head and foot adjustment), without side rails, without mattress	Prior authorization is required for billed charges greater than \$500. Reference policies for additional information.	HHO-DE-MP-1183 Beds, Accessories and Related Items
E0296	Hospital bed, total electric (head, foot and height adjustments), without side rails, with mattress	Prior authorization is required for billed charges greater than \$500. Reference policies for additional information.	HHO-DE-MP-1183 Beds, Accessories and Related Items
E0297	Hospital bed, total electric (head, foot and height adjustments), without side rails, without mattress	Prior authorization is required for billed charges greater than \$500. Reference policies for additional information.	HHO-DE-MP-1183 Beds, Accessories and Related Items
E0300	Pediatric crib, hospital grade, fully enclosed, with or without top enclosure	Prior authorization is required for billed charges greater than \$500. Reference policies for additional information.	HHO-DE-MP-1183 Beds, Accessories and Related Items
E0301	Hospital bed, heavy-duty, extra wide, with weight capacity greater than 350 pounds, but less than or equal to 600 pounds, with any type side rails, without mattress	Prior authorization is required for billed charges greater than \$500. Reference policies for additional information.	HHO-DE-MP-1183 Beds, Accessories and Related Items
E0302	Hospital bed, extra heavy-duty, extra wide, with weight capacity greater than 600 pounds, with any type side rails, without mattress	Prior authorization is required for billed charges greater than \$500. Reference policies for additional information.	HHO-DE-MP-1183 Beds, Accessories and Related Items
E0303	Hospital bed, heavy-duty, extra wide, with weight capacity greater than 350 pounds, but less than or equal to 600 pounds, with any type side rails, with mattress	Prior authorization is required for billed charges greater than \$500. Reference policies for additional information.	HHO-DE-MP-1183 Beds, Accessories and Related Items
E0304	Hospital bed, extra heavy-duty, extra wide, with weight capacity greater than 600 pounds, with any type side rails, with mattress	Prior authorization is required for billed charges greater than \$500. Reference policies for additional information.	HHO-DE-MP-1183 Beds, Accessories and Related Items
E0305	Bedside rails, half-length	Prior authorization is required for billed charges greater than \$500. Reference policies for additional information.	HHO-DE-MP-1183 Beds, Accessories and Related Items
E0310	Bedside rails, full-length	Prior authorization is required for billed charges greater than \$500. Reference policies for additional information.	HHO-DE-MP-1183 Beds, Accessories and Related Items
E0315	BED ACCESS: BOARD/TABL/SUPPRT DEVC	Prior authorization is required when the billed charges are greater than \$500.	
E0316	Safety enclosure frame/canopy for use with hospital bed, any type	Prior authorization is required for billed charges greater than \$500. Reference policies for additional information.	HHO-DE-MP-1183 Beds, Accessories and Related Items
E0325	URINAL; MALE JUG-TYPE ANY MATERIAL	Prior authorization is required when the billed charges are greater than \$500.	
E0326	URINAL; FE JUG-TYPE ANY MATERIAL	Prior authorization is required when the billed charges are greater than \$500.	
E0328	Hospital bed, pediatric, manual, 360 degree side enclosures, top of headboard, footboard and side rails up to 24 in above the spring, includes mattress	Prior authorization is required for billed charges greater than \$500. Reference policies for additional information.	HHO-DE-MP-1183 Beds, Accessories and Related Items
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[Hospital bed, pediatric, electric or semi-electric, 360 degree side enclosures, top of	Prior authorization is required for billed charges greater than \$500. Reference policies for	
E0329	headboard, footboard and side rails up to 24 in above the spring, includes mattress	additional information.	HHO-DE-MP-1183 Beds, Accessories and Related Items
E0350	CNTRL U ELEC BOWEL IRRIG/EVAC SYS	Prior authorization is required when the billed charges are greater than \$500.	
E0352	DISPBL PACK W/ELEC BOWEL IRRIG/EVAC	Prior authorization is required when the billed charges are greater than \$500.	
E0370	AIR PRESSURE ELEVATOR FOR HEEL	Prior authorization is required when the billed charges are greater than \$500.	
E0371	Nonpowered advanced pressure reducing overlay for mattress, standard mattress length and width	Prior authorization is required for billed charges greater than \$500. Reference policies for additional information.	HHO-DE-MP-1183 Beds, Accessories and Related Items
E0372	Powered air overlay for mattress, standard mattress length and width	Prior authorization is required for billed charges greater than \$500. Reference policies for additional information.	HHO-DE-MP-1183 Beds, Accessories and Related Items
E0373	Nonpowered advanced pressure reducing mattress	Prior authorization is required for billed charges greater than \$500. Reference policies for additional information.	HHO-DE-MP-1183 Beds, Accessories and Related Items
E0424	STATION COMPRS GASOUS O2 SYS RENT;	Prior authorization is required for billed charges greater than \$500. Reference policies for additional information.	HHO-DE-MP-1072 Oxygen
E0425	STATION COMPRS GAS SYS PURCHASE;	Prior authorization is required for billed charges greater than \$500. Reference policies for additional information.	HHO-DE-MP-1072 Oxygen
E0430	PRTBLE GASEOUS O2 SYS PURCHASE;	Prior authorization is required for billed charges greater than \$500. Reference policies for additional information.	HHO-DE-MP-1072 Oxygen
E0431	PRTBLE GASEOUS O2 SYS RENTAL;	Prior authorization is required for billed charges greater than \$500. Reference policies for additional information.	HHO-DE-MP-1072 Oxygen
E0433	PORTBL LIQ O2 SYS RENT; HOME LIQUIF	Prior authorization is required for billed charges greater than \$500. Reference policies for additional information.	HHO-DE-MP-1072 Oxygen
E0434	PRTBLE LIQUID O2 SYS RENTAL;	Prior authorization is required when the billed charges are greater than \$500.	
E0435	PRTBLE LIQUID O2 SYS PURCHASE;	Prior authorization is required for billed charges greater than \$500. Reference policies for additional information.	HHO-DE-MP-1072 Oxygen
E0439	STATION LIQUID O2 SYS RENTAL;	Prior authorization is required for billed charges greater than \$500. Reference policies for additional information.	HHO-DE-MP-1072 Oxygen
E0440	STATION LIQUID O2 SYS PURCHASE;	Prior authorization is required for billed charges greater than \$500. Reference policies for additional information.	HHO-DE-MP-1072 Oxygen and HHO-DE-MP-1030 Home Oxygen Therapy
E0441	STATIONARY O2 CONT GAS 1 MO SPL=1 U	Prior authorization is required for billed charges greater than \$500. Reference policies for additional information.	HHO-DE-MP-1072 Oxygen and HHO-DE-MP-1030 Home Oxygen Therapy
E0442	STATIONARY 02 CONT LQD 1 MO SPL=1 U	Prior authorization is required for billed charges greater than \$500. Reference policies for additional information.	HHO-DE-MP-1072 Oxygen and HHO-DE-MP-1030 Home Oxygen Therapy
E0443	PORTBL 02 CONTENT GAS 1 MO SPL= 1 U	Prior authorization is required for billed charges greater than \$500. Reference policies for additional information.	HHO-DE-MP-1072 Oxygen and HHO-DE-MP-1030 Home Oxygen Therapy
E0444	PORTBL 02 CONTENT LIQ 1 MO SPL=1 U	Prior authorization is required when the billed charges are greater than \$500.	
E0445	OXIMETER MSR BLD O2 LEVL NON-INVASV	Prior authorization is required for billed charges greater than \$500. Reference policies for additional information.	HHO-DE-MP-1072 Oxygen, Home Pulse Oximetry Devices HHO- DE-MP-1079 and HHO-DE-MP-1030 Home Oxygen Therapy
E0446	Topical oxygen delivery system, not otherwise specified, includes all supplies and accessories	Prior authorization is required for billed charges greater than \$500.	
E0447	P O C L 1M SPL=1U PRSC R/N XCD 4LPM	Prior authorization is required for billed charges greater than \$500. Reference policies for additional information.	HHO-DE-MP-1072 Oxygen and HHO-DE-MP-1030 Home Oxygen Therapy
E0455	O2 TENT EXCLD CROUP/PEDIATRIC TENTS	Prior authorization is required for billed charges greater than \$500. Reference policies for additional information.	HHO-DE-MP-1030 Home Oxygen Therapy
E0457	CHEST SHELL	Prior authorization is required when the billed charges are greater than \$500.	
E0459	CHEST WRAP	Prior authorization is required when the billed charges are greater than \$500.	
E0462	ROCKING BED W/WO SIDE RAILS	Prior authorization is required when the billed charges are greater than \$500.	
E0465	HOME VENT ANY TYPE USED INVASV INTF	Prior authorization is required when the billed charges are greater than \$500.	
E0466	HOME VENT TYPE USED NON-INVASV INTF	Prior authorization is required when the billed charges are greater than \$500.	
E0467	HOME VENTILATOR MULTI-FUNC RESP DVC	Prior authorization is required when the billed charges are greater than \$500.	
E0470	Respiratory assist device, bi-level pressure capability, without backup rate feature, used with noninvasive interface, e.g., nasal or facial mask (intermittent assist device with continuous positive airway pressure device)	Prior authorization is required for billed charges greater than \$500. Reference policies for additional information.	HHO-DE-MP-1063 Devices Used for the Treatment of Obstructive Sleep Apnea in Adults and HHO-DE-MP-1076 Respiratory Assist Devices
E0471	Respiratory assist device, bi-level pressure capability, with back-up rate feature, used with noninvasive interface, e.g., nasal or facial mask (intermittent assist device with continuous positive airway pressure device)	Prior authorization is required for billed charges greater than \$500. Reference policies for additional information.	HHO-DE-MP-1063 Devices Used for the Treatment of Obstructive Sleep Apnea in Adults and HHO-DE-MP-1076 Respiratory Assist Devices
E0472	Respiratory assist device, bi-level pressure capability, with backup rate feature, used with invasive interface, e.g., tracheostomy tube (intermittent assist device with continuous	Prior authorization is required for billed charges greater than \$500. Reference policies for additional information.	HHO-DE-MP-1076 Respiratory Assist Devices
F0480	positive airway pressure device)		
E0480 E0481	PERCUSSOR ELEC/PNEUMAT HOME MODEL INTRAPULM PERCUSS VENT SYS&RELACSS	Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500.	
E0481 E0482	COUGH STIM DEVC ALTRNAT POS&NEG	Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required for billed charges greater than \$500. Reference policies for additional information.	HHO-DE-MP-1141 High Frequency Chest Wall Oscillation Devices
E0483	HF CW OS SYS TH REG REC SIM EX OS Q	Prior authorization is required for billed charges greater than \$500. Reference policies for additional information.	HHO-DE-MP-1141 High Frequency Chest Wall Oscillation Devices
E0484	OSCILLAT POS EXPIRTORY PRSS NO-ELEC	Prior authorization is required when the billed charges are greater than \$500.	
E0485	Oral device/appliance used to reduce upper airway collapsibility, adjustable or nonadjustable, prefabricated, includes fitting and adjustment	Prior authorization is required when the billed charge is greater than \$500. Reference policies for additional information.	HHO-DE-MP-1065 Diagnosis and Treatment of Obstructive Sleep Apnea in Pediatric individuals and HHO-DE-MP-1063 Devices Used for the Treatment of Obstructive Sleep Apnea in
			Adults

			HHO-DE-MP-1065 Diagnosis and Treatment of Obstructive	
50.405	Oral device/appliance used to reduce upper airway collapsibility, adjustable or	Prior authorization is required when the billed charge is greater than \$500. Reference policies for	Sleep Apnea in Pediatric individuals and HHO-DE-MP-1063	
E0486	nonadjustable, custom fabricated, includes fitting and adjustment	additional information.	Devices Used for the Treatment of Obstructive Sleep Apnea in	
			Adults	
E0487	SPIROMETER ELECTRONIC INCLACCESS	Prior authorization is required when the billed charges are greater than \$500.	, deres	
E0500	IPPB MACH BUILT-IN NEBULZ;VALVS;PWR	Prior authorization is required when the billed charges are greater than \$500.		
EUSUU	IPPB MACH BUILT-IN NEBULZ;VALVS;PWR			
E0550	HUMDIFR EXT SUPLMNTL DUR IPPB TX/O2	Prior authorization is required for billed charges greater than \$500. Reference policies for	HHO-DE-MP-1072 Oxygen and HHO-DE-MP-1030 Home	
		additional information.	Oxygen Therapy	
E0555	HUMDIFR GLASS/AUTOCLVBL PLSTC BOTTL	Prior authorization is required for billed charges greater than \$500. Reference policies for	HHO-DE-MP-1030 Home Oxygen Therapy	
20555	HOWDIFK GLASS/AUTOCEVBE FESTE BOTTE	additional information.	Thio-DE-WF-1030 Home Oxygen merapy	
505.00		Prior authorization is required for billed charges greater than \$500. Reference policies for	HHO-DE-MP-1072 Oxygen and HHO-DE-MP-1030 Home	
E0560	HUM DIFIR SUPLM NTL DUR IPPB TX/O2	additional information.	Oxygen Therapy	
			HHO-DE-MP-1063 Devices Used for the Treatment of	
E0561	the state of the second st	Prior authorization is required for billed charges greater than \$500. Reference policies for	Obstructive Sleep Apnea in Adults and HHO-DE-MP-1076	
E0561	Humidifier, nonheated, used with positive airway pressure device	additional information.		
			Respiratory Assist Devices	
		Prior authorization is required for billed charges greater than \$500. Reference policies for	HHO-DE-MP-1063 Devices Used for the Treatment of	
E0562	Humidifier, heated, used with positive airway pressure device	additional information.	Obstructive Sleep Apnea in Adults and HHO-DE-MP-1076	
		additional mormation.	Respiratory Assist Devices	
E0565	COMPRS AIR PWR EQP NOT SLF-CONTAIND	Prior authorization is required when the billed charges are greater than \$500.		
E0570	NEBULIZER WITH COMPRESSOR	Prior authorization is required when the billed charges are greater than \$500.		
E0570	AROSL COMPRS ADJSTBL PRSS INTERMIT	Prior authorization is required when the billed charges are greater than \$500.		
E0574	US/ELEC AROSL GEN W/SM VOLUME NEB	Prior authorization is required when the billed charges are greater than \$500.		
E0575	NEBULIZER ULTRASONIC LARGE VOLUME	Prior authorization is required when the billed charges are greater than \$500.		
E0580	NEBULIZR GLASS/AUTOCLVBL PLST BOTTL	Prior authorization is required when the billed charges are greater than \$500.		
	· · · · ·	Prior authorization is required for billed charges greater than \$500. Reference policies for	HHO-DE-MP-1072 Oxygen and HHO-DE-MP-1030 Home	
E0585	NEBULIZER W/COM PRESSOR AND HEATER	additional information.	Oxygen Therapy	
		Prior authorization is required for billed charges greater than \$500. Reference policies for	HHO-DE-MP-1063 Devices Used for the Treatment of	
E0600	Respiratory suction pump, home model, portable or stationary, electric			
		additional information.	Obstructive Sleep Apnea in Adults	
			HHO-DE-MP-1065 Diagnosis and Treatment of Obstructive	
E0601		Prior authorization is required when the billed charge is greater than \$500. Reference policies for	Sleep Apnea in Pediatric individuals and HHO-DE-MP-1063	
EUBUI	Continuous positive airway pressure (CPAP) device	additional information.	Devices Used for the Treatment of Obstructive Sleep Apnea in	
			Adults	
E0603	BREAST PUMP ELECTRIC ANY TYPE		Addits	
		Prior authorization is required when the billed charges are greater than \$500.		
E0604	Breast pump, hospital grade, electric (AC and/or DC), any type	Prior authorization is required.		
E0605	VAPORIZER ROOM TYPE	Prior authorization is required when the billed charges are greater than \$500.		
E0606	POSTURAL DRAINAGE BOARD	Prior authorization is required when the billed charges are greater than \$500.		
E0607	HOME BLOOD GLUCOSE MONITOR	Prior authorization is required when the billed charges are greater than \$500.		
E0610	PACEMKR MON CHCK BATTRY AUDBL&VISBL	Prior authorization is required when the billed charges are greater than \$500.		
E0615	PACEMIKR MON CHCK BATTRY DIGTL/VISBL	Prior authorization is required when the billed charges are greater than \$500.		
E0616				
	IMPL CARD EVNT REC MEM ACTVTR&PRGMR	Prior authorization is required when the billed charges are greater than \$500.		
E0617	IMPL CARD EVNT REC MEM ACTVTR&PRGMR EXT DEFIB W/INTEGRATED ECG ANALY	Prior authorization is required when the billed charges are greater than \$500.		
E0617	EXT DEFIB W/INTEGRATED ECG ANALY		HHO-DE-MP-1065 Diagnosis and Treatment of Obstructive	
		Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charge is greater than \$500. Reference policies for	HHO-DE-MP-1065 Diagnosis and Treatment of Obstructive Sleep Apnea in Pediatric individuals	
E0617 E0618	EXT DEFIB W/INTEGRATED ECG ANALY Apnea monitor, without recording feature	Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charge is greater than \$500. Reference policies for additional information.	Sleep Apnea in Pediatric individuals	
E0617	EXT DEFIB W/INTEGRATED ECG ANALY	Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charge is greater than \$500. Reference policies for additional information. Prior authorization is required when the billed charge is greater than \$500. Reference policies for	Sleep Apnea in Pediatric individuals HHO-DE-MP-1065 Diagnosis and Treatment of Obstructive	
E0617 E0618 E0619	EXT DEFIB W/INTEGRATED ECG ANALY Apnea monitor, without recording feature Apnea monitor, with recording feature	Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charge is greater than \$500. Reference policies for additional information. Prior authorization is required when the billed charge is greater than \$500. Reference policies for additional information.	Sleep Apnea in Pediatric individuals	
E0617 E0618 E0619 E0620	EXT DEFIB W/INTEGRATED ECG ANALY Apnea monitor, without recording feature Apnea monitor, with recording feature SKN PIERC DEVC CLCT CAPLRY BLD LASR	Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charge is greater than \$500. Reference policies for additional information. Prior authorization is required when the billed charge is greater than \$500. Reference policies for additional information. Prior authorization is required when the billed charges are greater than \$500.	Sleep Apnea in Pediatric individuals HHO-DE-MP-1065 Diagnosis and Treatment of Obstructive	
E0617 E0618 E0619 E0620 E0621	EXT DEFIB W/INTEGRATED ECG ANALY Apnea monitor, without recording feature Apnea monitor, with recording feature SKN PIERC DEVC CLCT CAPLRY BLD LASR SLING/SEAT PT LIFT CANNAS/MYLON	Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charge is greater than \$500. Reference policies for additional information. Prior authorization is required when the billed charge is greater than \$500. Reference policies for additional information. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500.	Sleep Apnea in Pediatric individuals HHO-DE-MP-1065 Diagnosis and Treatment of Obstructive	
E0617 E0618 E0619 E0620 E0621 E0625	EXT DEFIB W/INTEGRATED ECG ANALY Apnea monitor, without recording feature Apnea monitor, with recording feature SKN PIERC DEVC CLCT CAPLRY BLD LASR SLING/SEAT PT LIFT CANVAS/NYLON Patient IIf, bathroom or toilet, not otherwise classified	Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charge is greater than \$500. Reference policies for additional information. Prior authorization is required when the billed charge is greater than \$500. Reference policies for additional information. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required for billed charges are greater than \$500.	Sleep Apnea in Pediatric individuals HHO-DE-MP-1065 Diagnosis and Treatment of Obstructive	
E0617 E0618 E0619 E0620 E0621	EXT DEFIB W/INTEGRATED ECG ANALY Apnea monitor, without recording feature Apnea monitor, with recording feature SKN PIERC DEVC CLCT CAPLRY BLD LASR SLING/SEAT PT LIFT CANNAS/MYLON	Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charge is greater than \$500. Reference policies for additional information. Prior authorization is required when the billed charge is greater than \$500. Reference policies for additional information. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500.	Sleep Apnea in Pediatric individuals HHO-DE-MP-1065 Diagnosis and Treatment of Obstructive	
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E0657	SEG PNEUMAT APPLINC W/COMPRS CHEST	Prior authorization is required for billed charges greater than \$500. Reference policies for additional information.	HHO-DE-MP-1144 Pneumatic Compression Devices	
E0660	NONSEG PNEUMAT APPLINC FULL LEG	Prior authorization is required for billed charges greater than \$500. Reference policies for additional information.	HHO-DE-MP-1144 Pneumatic Compression Devices	
E0665	NONSEG PNEUMAT APPLINC FULL ARM	Prior authorization is required for billed charges greater than \$500. Reference policies for additional information.	HHO-DE-MP-1144 Pneumatic Compression Devices	
E0666	NONSEG PNEUMAT APPLINC HALF LEG	Prior authorization is required for billed charges greater than \$500. Reference policies for additional information.	HHO-DE-MP-1144 Pneumatic Compression Devices	
E0667	SEG PNEUMAT APPLINC COMPRS FULL LEG	Prior authorization is required for billed charges greater than \$500. Reference policies for additional information.	HHO-DE-MP-1144 Pneumatic Compression Devices	
E0668	SEG PNEUMAT APPLINC COMPRS FULL ARM	Prior authorization is required for billed charges greater than \$500. Reference policies for additional information.	HHO-DE-MP-1144 Pneumatic Compression Devices	
E0669	SEG PNEUMAT APPLINC COMPRS HALF LEG	Prior authorization is required for billed charges greater than \$500. Reference policies for additional information.	HHO-DE-MP-1144 Pneumatic Compression Devices	
E0670	SEG PNEU APPL P C INT 2 F LEG TRNK	Prior authorization is required for billed charges greater than \$500. Reference policies for additional information.	HHO-DE-MP-1144 Pneumatic Compression Devices	
E0671	SEG GRAD PRSS PNUMAT APPLNC FUL LEG	Prior authorization is required when the billed charges are greater than \$500.		
E0672	SEG GRAD PRSS PNUMAT APPLNC FUL ARM	Prior authorization is required when the billed charges are greater than \$500.		
E0673	SEG GRAD PRSS PNUMAT APPLNC HLF LEG	Prior authorization is required when the billed charges are greater than \$500.		
E0675	PNEUMAT COMPRS DEVC HI PRESS RAPID	Prior authorization is required for billed charges greater than \$500. Reference policies for additional information.	HHO-DE-MP-1144 Pneumatic Compression Devices	
E0676	INTERMITT LIMB COMPRESSION DEVC NOS	Prior authorization is required for billed charges greater than \$500. Reference policies for additional information.	HHO-DE-MP-1144 Pneumatic Compression Devices	
E0678	Non-pneumatic sequential compression garment, full leg	Prior authorization is required when the billed charges are greater than \$500.		
E0679	Non-pneumatic sequential compression garment, half leg	Prior authorization is required when the billed charges are greater than \$500.		
E0680	Non-pneumatic compression controller with sequential calibrated gradient pressure	Prior authorization is required when the billed charges are greater than \$500.		
E0681	Non-pneumatic compression controller without calibrated gradient pressure	Prior authorization is required when the billed charges are greater than \$500.		
E0682	Non-pneumatic sequential compression garment, full arm	Prior authorization is required when the billed charges are greater than \$500.		
E0691	UV LIGHT TX BULB/LAMP; TX 2 SQ FT/<	Prior authorization is required when the billed charges are greater than \$500.		
E0692	UV LT TX SYS PANL W/LAMP 4 FT PANEL	Prior authorization is required when the billed charges are greater than \$500.		
E0693	UV LT TX SYS PANL W/LAMP 6 FT PANEL	Prior authorization is required when the billed charges are greater than \$500.		
E0694	UV MX DIR LT TX SYS 6 FT CABINET	Prior authorization is required when the billed charges are greater than \$500.		
E0700	SAFETY EQP DEVICE/ACCESSRY ANY TYPE	Prior authorization is required when the billed charges are greater than \$500.		
E0705	TRANSFER DEVICE ANY TYPE EACH	Prior authorization is required when the billed charges are greater than \$500.		
E0710	RESTRAINT ANY TYPE	Prior authorization is required when the billed charges are greater than \$500.		
E0720	Transcutaneous electrical nerve stimulation (TENS) device, two-lead, localized stimulation	Prior authorization is required for billed charges greater than \$500. Reference policies for additional information.	HHO-DE-MP-1136 Temporomandibular Joint Dysfunction	
E0730	Transcutaneous electrical nerve stimulation (TENS) device, four or more leads, for multiple nerve stimulation	Prior authorization is required for billed charges greater than \$500. Reference policies for additional information.	HHO-DE-MP-1136 Temporomandibular Joint Dysfunction	
E0731	Form-fitting conductive garment for delivery of TENS or NMES (with conductive fibers separated from the patient's skin by layers of fabric)	Prior authorization is required for billed charges greater than \$500.		
E0740	N-IMPL PELV FLR ELEC STIM CMPL SYS	Prior authorization is required when the billed charges are greater than \$500.		
E0744	NEUROM USCULAR STIMULATOR SCOLIOSIS	Prior authorization is required when the billed charges are greater than \$500.		
E0745	Neuromuscular stimulator, electronic shock unit	Prior authorization is required for billed charges greater than \$500. Reference policies for additional information.	HHO-DE-MP-1185 Functional Neuromuscular Electrical Stimulation and Other Electrical Stimulator	
E0746	ELECTROMYOGRAPHY BIOFEEDBACK DEVICE	Prior authorization is required when the billed charges are greater than \$500.		
E0747	Osteogenesis stimulator, electrical, noninvasive, other than spinal applications	Prior authorization is required for billed charges greater than \$500. Reference policies for additional information.	HHO-DE-MP-1251 Ultrasound Osteogenesis Stimulator and HHO-DE-MP-1149 Non-Spinal Bone Growth Stimulation	
E0748	Osteogenesis stimulator, electrical, noninvasive, spinal applications	Prior authorization is managed by EviCore for billed charges greater than \$500. Reference policies for additional information.	HHO-DE-MP-1148 Electrical Bone Growth Stimulation Spinal	Prior authorization is managed by EviCore.
E0749	Osteogenesis stimulator, electrical, surgically implanted	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
E0755	ELEC SALIVARY REFLEX STIMULATOR	Prior authorization is required when the billed charges are greater than \$500.		
E0760	Osteogenesis stimulator, low intensity ultrasound, noninvasive	Prior authorization is required for billed charges greater than \$500. Reference policies for additional information.	HHO-DE-MP-1251 Ultrasound Osteogenesis Stimulator	
E0761	NON-THRML PULS RADIOWAVE ELECMAGNET	Prior authorization is required when the billed charges are greater than \$500.		
E0762	TRANSCUT ELEC JOINT STIM DEVC SYS	Prior authorization is required when the billed charges are greater than \$500.		
E0764	Functional neuromuscular stimulation, transcutaneous stimulation of sequential muscle groups of ambulation with computer control, used for walking by spinal cord injured, entire	Prior authorization is required for billed charges greater than \$500. Reference policies for additional information.	HHO-DE-MP-1185 Functional Neuromuscular Electrical Stimulation and Other Electrical Stimulator	
	system, after completion of training program			
E0765 E0766	FDA APPRVD NRV STIM TX NAUSA&VOMIT Electrical stimulation device used for cancer treatment, includes all accessories, any type	Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required for billed charges greater than \$500. Reference policies for	HHO-DE-MP-1244 Tumor Treatment fields	
E0769	Electrical stimulation or electromagnetic wound treatment device, not otherwise classified	additional information. Prior authorization is required for billed charges greater than \$500.		
E0770	Functional electrical stimulator, transcutaneous stimulation of nerve and/or muscle groups,	Prior authorization is required for billed charges greater than \$500. Reference policies for	HHO-DE-MP-1185 Functional Neuromuscular Electrical	
50770	any type, complete system, not otherwise specified	additional information.	Stimulation and Other Electrical Stimulator	
E0776	IV POLE	Prior authorization is required when the billed charges are greater than \$500.		1

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E0951 HEELLOOP/HOLDERAWTYPE EACH Prior authorization is required when the billed charges are greater than \$500.	
E0952 TOE LOOP/HOLDER ANY TYPE EACH Prior authorization is required when the billed charges are greater than \$500.	
E0953 WC AC LAT THIGH/KNEE SUPP ANY TY EA Prior authorization is required when the billed charges are greater than \$500.	
E0954 WHEELCHAIR AC FOOT BOX ANY TY EAFT Prior authorization is required when the billed charges are greater than \$500.	
E0955 WC ACSS HEADREST CUSHND HARDWARE EA Prior authorization is required when the billed charges are greater than \$500. E0956 WC ACSS LAT TRNK/HIP HARDWARE EA Prior authorization is required when the billed charges are greater than \$500.	
EU956 WC ACSS LAT I KNK/HIP HARDWARE EA Prior authorization is required when the billed charges are greater than \$500. E0957 WC ACSS MED THI SUPP HARDWARE EA Prior authorization is required when the billed charges are greater than \$500.	
E0957 WCACSS MED IN SUPPRAVWARE EA Prior authorization is required when the billed charges are greater than 5500. E0958 MNLWCACCESS 1-ARM DRIVE ATTOHEA Prior authorization is required when the billed charges are greater than 5500.	
E0959 MNLWCACCSS LAW DWEATHER A Prior automation is required when the billed charges are greater than 5500.	
E0950 WCKCKCS SHDR HENCKAWFOLCE A FING authorization is required when the billed charges are greater than 5500.	
E090 WCACES SINCERING STATES THE Prior authorization is required when the billed charges are greater than 5500. E091 MNL WCACCESS WHL LOCK BRAKE EXT EA Prior authorization is required when the billed charges are greater than 5500.	<u> </u>
E0966 MML WCACCESS HEADREST EXTENSION EA Prior authorization is required which we builde chargestie greater than \$500.	<u> </u>
E0907 MML MCACHND RIM PROTREPLONE A Prior authorization is required when the billed charges are greater than 5500.	
E0968 COMMODE SEAT WHEELCHAIR Prior authorization is required when the billed charges are greater than \$500.	<u> </u>
E0969 NARROWING DEVICE WHEELCHAIR Prior authorization is required when the billed charges are greater than \$500.	<u> </u>
E0970 NO 2 FOOTPLATES EXCEPT ELEV LEGREST Prior authorization is required when the billed charges are greater than \$500.	<u> </u>
E0971 MML CACSS ANTI-TIPPING DEVCEA Prior authorization is required when the billed charges are greater than \$500.	<u> </u>
E0973 WC ACCSS ADJ HT DTACH ARMRST EA Prior authorization is required when the billed charges are greater than \$500.	
E0974 MNL WC ACCESS ANTI-ROLLBACK DEVC EA Prior authorization is required when the billed charges are greater than \$500.	

E0978	WC ACSS PSTN/SFTY BELT/PELV STRP EA	Prior authorization is required when the billed charges are greater than \$500.	
E0980	SAFETY VEST WHEELCHAIR	Prior authorization is required when the billed charges are greater than \$500.	
E0981	WC ACSS SEAT UPHLSTER REPL ONLY EA	Prior authorization is required when the billed charges are greater than \$500.	
E0982	WC ACSS BACK UPHLSTER REPL ONLY EA	Prior authorization is required when the billed charges are greater than \$500.	
E0983	MNL WC ACSS PWR ADD-ON CNVRT MNL WC	Prior authorization is required when the billed charges are greater than \$500.	
E0984	MNL WC ACSS PWR ADD-ON CNVRT MNL WC	Prior authorization is required when the billed charges are greater than \$500.	
E0985	WHEELCHAIR ACCESS SEAT LIFT MECH	Prior authorization is required when the billed charges are greater than \$500.	
E0986	MNL WC ACSS PSH-RM ACT PWR ASST SYS	Prior authorization is required when the billed charges are greater than \$500.	
E0988	MNL WC ACSS LEVR-ACT WHL DRIVE PAIR	Prior authorization is required when the billed charges are greater than \$500.	
E0990	WC ACCSS ELEV LEG REST CMPL ASSMBL	Prior authorization is required when the billed charges are greater than \$500.	
E0992	MNL WHLCHAIR ACCSS SOLID SEAT INSRT	Prior authorization is required when the billed charges are greater than \$500.	
E0994	ARMREST EACH	Prior authorization is required when the billed charges are greater than \$500.	
E0995	WC AC CALF REST/PAD REPLONLY EA	Prior authorization is required when the billed charges are greater than \$500.	
E1002	WC ACSS PWR SEATING SYS TILT ONLY	Prior authorization is required when the billed charges are greater than \$500.	
E1003	WC ACSS RECLINE ONLY NO SHEAR RDUC	Prior authorization is required when the billed charges are greater than \$500.	
E1004	WC ACSS RECLINE W/MECH SHEAR RDUC	Prior authorization is required when the billed charges are greater than \$500.	
E1005	WC ACSS RECLINE W/PWR SHEAR RDUC	Prior authorization is required when the billed charges are greater than \$500.	
E1006	WC ACSS TILT&RECLINE NO SHEAR RDUC	Prior authorization is required when the billed charges are greater than \$500.	
E1007	WC ACSS TILT&RECLIN MECH SHEAR RDUC	Prior authorization is required when the billed charges are greater than \$500.	
E1008	WC ACSS TILT&RECLINE PWR SHEAR RDUC	Prior authorization is required when the billed charges are greater than \$500.	
E1009	WC ACCSS MECH LINKD LEG ELEV EA	Prior authorization is required when the billed charges are greater than \$500.	
E1010	WC ACCSS PWR LEG ELEV SYS PAIR	Prior authorization is required when the billed charges are greater than \$500.	
E1011	MOD PED SIZE WC WIDTH ADJ PACKAGE	Prior authorization is required when the billed charges are greater than \$500.	<u> </u>
E1012	WC ACCESS PWR SEAT SYS CNTR MNT EA	Prior authorization is required when the billed charges are greater than \$500.	
E1014	RECLIN BACK ADD PED SIZE WHICHAIR	Prior authorization is required when the billed charges are greater than \$500.	<u> </u>
E1015 E1016	SHOCK ABSORBER MANUAL WHEELCHAIR EA	Prior authorization is required when the billed charges are greater than \$500.	<u> </u>
E1016 E1017	SHOCK ABSORBER POWER WHEELCHAIR EA HEAVY DUTY SHOCK ABSORBR MNL WC EA	Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500.	
E1017 E1018	HEAVY DUTY SHOCK ABSORBR MINE WC EA	Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500.	
E1018 E1020	RES LIMB SUP SYS WHEELCHAIR ANY TYP	Prior authorization is required when the billed charges are greater than \$500.	
E1020	WC ACCSS MANL SWINGAWAY OTH CNTRL	Prior authorization is required when the billed charges are greater than \$500.	
E1028	WHEELCHAIR ACCESS VENT TRAY FIX	Prior authorization is required when the billed charges are greater than \$500.	
E1025	WHELCHAIR ACCESS VENT TRAY FIX	Prior authorization is required when the billed charges are greater than \$500.	
E1030	ROLLABOUT CHAIR W/CASTRS 5 IN/GT	Prior authorization is required when the billed charges are greater than \$500.	
E1031	MX-PSTN PT TRNSF SYS PT = 300 LBS</td <td>Prior authorization is required when the billed charges are greater than \$500.</td> <td></td>	Prior authorization is required when the billed charges are greater than \$500.	
E1036	MX-PSTN PT TRNSF SYS PT > 300 LBS	Prior authorization is required when the billed charges are greater than \$500.	
E1037	TRANSPORT CHAIR PEDIATRIC SIZE	Prior authorization is required when the billed charges are greater than \$500.	
E1038	TRNSPRT CHAIR PT WT CAP TO&= 300 LB	Prior authorization is required when the billed charges are greater than \$500.	
E1039	TRNSPRT CHAIR ADLT PT WT CAP>300 LB	Prior authorization is required when the billed charges are greater than \$500.	
E1050	FULL RECLINE WC FIX ARM DETACH LEGS	Prior authorization is required when the billed charges are greater than \$500.	
E1060	FULL RECLN WHLCHAR; DTACH ARM LEGRST	Prior authorization is required when the billed charges are greater than \$500.	
E1070	FULL RECLN WHLCHR; DTACH ARM FOOTRST	Prior authorization is required when the billed charges are greater than \$500.	
E1083	HEMI-W/C; FIXED ARM DETACH LEGREST	Prior authorization is required when the billed charges are greater than \$500.	
E1084	HEMI-WHLCHAIR; DTACHBLE ARMS LEGRST	Prior authorization is required when the billed charges are greater than \$500.	
E1085	HEMI-WHLCHAIR; FIX ARM DTACH FOOTRST	Prior authorization is required when the billed charges are greater than \$500.	
E1086	HEMI-WHLCHAIR; DTACHBLARMS FOOTRST	Prior authorization is required when the billed charges are greater than \$500.	
E1087	HI-STRGTH WHLCHAIR; FIX ARMS LEGRST	Prior authorization is required when the billed charges are greater than \$500.	
E1088	HI-STRGTH WHLCHAIR; DTACH ARM LEGRST	Prior authorization is required when the billed charges are greater than \$500.	
E1089	HI-STRGTH WHLCHAIR; FIX ARM FOOTRST	Prior authorization is required when the billed charges are greater than \$500.	
E1090	HI-STRGTH WHLCHAR; DTACH ARM FOOTRST	Prior authorization is required when the billed charges are greater than \$500.	
E1092	WIDE HEVY-DUT WHLCHR; DTACH ARM LEG	Prior authorization is required when the billed charges are greater than \$500.	
E1093	WIDE HEVY-DUT WHLCHR; DTACH ARM FOOT	Prior authorization is required when the billed charges are greater than \$500.	
E1100	SEMI-RECLN WHLCHR; FIX ARM DTACH LEG	Prior authorization is required when the billed charges are greater than \$500.	
E1110	SEMI-RECLN WHLCHR; DTACH ARM LEGRST	Prior authorization is required when the billed charges are greater than \$500.	
E1130	STD WHLCHAIR; FIX ARM DTACH FOOTRST	Prior authorization is required when the billed charges are greater than \$500.	
E1140	WHLCHAIR; DTACHBLE ARMS FOOTRESTS	Prior authorization is required when the billed charges are greater than \$500.	
E1150	WHLCHAIR; DTACHBLE ARMS LEGRESTS	Prior authorization is required when the billed charges are greater than \$500.	
E1160	WHLCHAIR; FIX ARMS DTACHBL LEGRESTS	Prior authorization is required when the billed charges are greater than \$500.	
E1161	MANUAL ADLT SZ WC INCL TILT SPACE	Prior authorization is required when the billed charges are greater than \$500.	
E1170	AMP WHLCHAIR; FIX ARM DTACH LEGREST	Prior authorization is required when the billed charges are greater than \$500.	<u> </u>
E1171	AMP WHICHAIR; FIX ARM NO FOOT/LEGRST	Prior authorization is required when the billed charges are greater than \$500.	
E1172	AMP WHLCHR; DTACH ARM NO FOOT/LEGRST	Prior authorization is required when the billed charges are greater than \$500.	
E1180	AMP WHICHAIR; DTACHBLARMS FOOTRSTS	Prior authorization is required when the billed charges are greater than \$500.	<u> </u>
E1190 E1195	AMP WHICHAIR; DTACHBL ARMS LEGRESTS	Prior authorization is required when the billed charges are greater than \$500.	<u> </u>
E1195	HVY DUT WHLCHR; FIX ARM DTACH LEGRST	Prior authorization is required when the billed charges are greater than \$500.	
	AMD WHICHAID: ELY ADDA DTACU FOOTDET	Prior authorization is required when the billed charges are greater than 6500	
E1200	AMP WHLCHAIR; FIX ARM DTACH FOOTRST	Prior authorization is required when the billed charges are greater than \$500.	
	AMP WHLCHAIR; FIX ARM DTACH FOOTRST WHEELCHAIR; SPCL SIZED/CONSTRUCTED WHEELCHAIR WITH FIXED ARM FOOTRESTS	Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500.	

E1222	WHEELCHAIR W/FIX ARM ELEV LEGRESTS	Prior authorization is required when the billed charges are greater than \$500.		
E1223	WHLCHAIR W/DETACHBLE ARMS FOOTRESTS	Prior authorization is required when the billed charges are greater than \$500.		
E1224	WHLCHAIR W/DTACHBL ARMS ELEV LEGRST	Prior authorization is required when the billed charges are greater than \$500.		
E1225	WC ACCESS MNL SEMIRECLINING BACK EA	Prior authorization is required when the billed charges are greater than \$500.		
E1226	WC ACCESS MNL FULL RECLIN BACK EA	Prior authorization is required when the billed charges are greater than \$500.		
E1227	SPECIAL HEIGHT ARMS FOR WHEELCHAIR	Prior authorization is required when the billed charges are greater than \$500.		
E1228	SPECIAL BACK HEIGHT FOR WHEELCHAIR	Prior authorization is required when the billed charges are greater than \$500.		
E1229	Wheelchair, pediatric size, not otherwise specified	Prior authorization is required for billed charges greater than \$500.		
E1230	PWR OP VEH SPEC BRAND&MODEL NUMBER	Prior authorization is required when the billed charges are greater than \$500.		
E1231	WC PED SZ TILT-IN-SPACE RIGD W/SEAT	Prior authorization is required when the billed charges are greater than \$500.		-
E1232	WC PED SZ TILT-IN-SPACE FOLD W/SEAT	Prior authorization is required when the billed charges are greater than \$500.		
E1233	WC PED SZ TILT-IN-SPCE RIGD NO SEAT	Prior authorization is required when the billed charges are greater than \$500.		
E1234	WC PED SZ TILT-IN-SPCE FOLD NO SEAT	Prior authorization is required when the billed charges are greater than \$500.		
E1235	WCPED SZ RIGD ADJUSTBL W/SEAT SYS	Prior authorization is required when the billed charges are greater than \$500.	-	
E1235	WC PED SZ FOLD ADJUSTBL W/SEAT SYS	Prior authorization is required when the billed charges are greater than \$500.	-	-
E1236 E1237	WC PED SZ FOLD ADJOSTBL WYSEAT SYS WC PED SZ RIGD ADJUSTBL NO SEAT SYS		-	
		Prior authorization is required when the billed charges are greater than \$500.	-	
E1238	WC PED SZ FOLD ADJUSTBL NO SEAT SYS	Prior authorization is required when the billed charges are greater than \$500.		
E1239	Power wheelchair, pediatric size, not otherwise specified	Prior authorization is required for billed charges greater than \$500.		
E1240	LGHTWT WHLCHAIR; DTACH ARMS LEGRSTS	Prior authorization is required when the billed charges are greater than \$500.		
E1250	LGHTWT WHLCHR; FIX ARM DTACH FOOTRST	Prior authorization is required when the billed charges are greater than \$500.		
E1260	LGHTWT WHLCHAIR; DTACH ARMS FOOTRST	Prior authorization is required when the billed charges are greater than \$500.		
E1270	LGHTWT WHLCHR; FIX ARM DTACH LEGRST	Prior authorization is required when the billed charges are greater than \$500.		
E1280	HEVY-DUTY WHLCHR; DTACH ARMS LEGRST	Prior authorization is required when the billed charges are greater than \$500.		
E1285	HEVY-DUTY WHLCHR; FIX ARM DTACH FOOT	Prior authorization is required when the billed charges are greater than \$500.		
E1290	HEVY-DUTY WHLCHR; DTACH ARM FOOTRST	Prior authorization is required when the billed charges are greater than \$500.		
E1295	HEVY-DUTY WHLCHAIR; FIX ARMS LEGRST	Prior authorization is required when the billed charges are greater than \$500.		
E1296	SPECIAL WHEELCHAIR SEAT HT FROM FLR	Prior authorization is required when the billed charges are greater than \$500.		
E1297	SPECIAL WHLCHAIR SEAT DEPTH UPHLSTR	Prior authorization is required when the billed charges are greater than \$500.		
E1298	SPCL WHLCHAIR SEAT DPTH&/WDTH CNSTR	Prior authorization is required when the billed charges are greater than \$500.		
E1300	WHIRLPOOL PORTABLE	Prior authorization is required when the billed charges are greater than \$500.		
E1310	WHIRLPOOL NONPORTABLE	Prior authorization is required when the billed charges are greater than \$500.		
		Prior authorization is required for billed charges greater than \$500. Reference policies for	HHO-DE-MP-1072 Oxygen and HHO-DE-MP-1030 Home	
E1352	OXYGEN ACC FLW REG CPBL POS INSP PR	additional information.	Oxygen Therapy	
		Prior authorization is required for billed charges greater than \$500. Reference policies for	HHO-DE-MP-1072 Oxygen and HHO-DE-MP-1030 Home	
E1353	REGULATOR	additional information.	Oxygen Therapy	
		Prior authorization is required for billed charges greater than \$500. Reference policies for	HHO-DE-MP-1072 Oxygen and HHO-DE-MP-1030 Home	
E1354	O2 ACCESS CART PRTBLE CYL/CONC REPL	additional information.	Oxygen Therapy	
-		Prior authorization is required for billed charges greater than \$500. Reference policies for	HHO-DE-MP-1072 Oxygen and HHO-DE-MP-1030 Home	
E1355	STAND/RACK	additional information.	Oxygen Therapy	
E1356	O2 ACCESS BTTRY PACK/CRTRDGE REPL	Prior authorization is required when the billed charges are greater than \$500.	oxygen merupy	
E1350	OZ ACCESS BITKI FACKYCKTKDGE KEFE	Prior authorization is required for billed charges greater than \$500. Reference policies for	HHO-DE-MP-1072 Oxygen and HHO-DE-MP-1030 Home	
E1357	O2 ACCESS BATTRY CHARGER REPLEA	additional information.	Oxygen Therapy	
		Prior authorization is required for billed charges greater than \$500. Reference policies for	HHO-DE-MP-1072 Oxygen and HHO-DE-MP-1030 Home	
E1358	O2 ACCESS DC POWER ADAPTER REPL EA	additional information.	Oxygen Therapy	
54.0.70			Oxygen merapy	
E1372	IMMERSION EXTERNAL HEATER NEBULIZER	Prior authorization is required when the billed charges are greater than \$500.		
E1390	O2 CONC 85%/>02 CONC PRSC FLW RATE	Prior authorization is required for billed charges greater than \$500. Reference policies for	HHO-DE-MP-1072 Oxygen and HHO-DE-MP-1030 Home	
		additional information.	Oxygen Therapy	
E1391	02 CONC 2 DEL 85%/>02 CONC FLW RATE	Prior authorization is required for billed charges greater than \$500. Reference policies for	HHO-DE-MP-1072 Oxygen and HHO-DE-MP-1030 Home	
-		additional information.	Oxygen Therapy	
E1392	PORTABLE OXYGEN CONCENTRATOR RENTAL	Prior authorization is required for billed charges greater than \$500. Reference policies for	HHO-DE-MP-1072 Oxygen and HHO-DE-MP-1030 Home	
		additional information.	Oxygen Therapy	
		Prior authorization is required for billed charges greater than \$500. Reference policies for	HHO-DE-MP-1134 Portable External Infusion Pump, Home	
E1399	Durable medical equipment, miscellaneous	additional information.	Oxygen Therapy HHO-DE-MP-1030, Pneumatic Compression	
			Devices HHO-DE-MP-1144 and HHO-DE-MP-1072 Oxygen	
E1405	O2&WATR VAPR ENRICH SYS W/HEAT DEL	Prior authorization is required for billed charges greater than \$500. Reference policies for	HHO-DE-MP-1072 Oxygen and HHO-DE-MP-1030 Home	
L1-0J		additional information.	Oxygen Therapy	
E1406	O2&WATR VAPR ENRCH SYS NO HEAT DEL	Prior authorization is required for billed charges greater than \$500. Reference policies for	HHO-DE-MP-1072 Oxygen and HHO-DE-MP-1030 Home	
		additional information.	Oxygen Therapy	
E1500	CENTRIFUGE FOR DIALYSIS	Prior authorization is required when the billed charges are greater than \$500.		
E1510	KIDNEY DIALYSAT DEL SYS KIDNEY MACH	Prior authorization is required when the billed charges are greater than \$500.		
E1520		Prior authorization is required for billed charges greater than \$500. Reference policies for	UNO DE MD 1246 Harra Distuis Environment - 16 - 1	
E1520	HEPARIN INFUSION PUMP HEMODIALYSIS	additional information.	HHO-DE-MP-1246 Home Dialysis Equipment and Supplies	
21520				
		Prior authorization is required for billed charges greater than \$500. Reference policies for		
E1530	AIR BUBBLE DETECTR HEMODIAL EA REPL	Prior authorization is required for billed charges greater than \$500. Reference policies for additional information.	HHO-DE-MP-1246 Home Dialysis Equipment and Supplies	
E1530		additional information.		
	AIR BUBBLE DETECTR HEMODIAL EA REPL PRESSURE ALARM HEMODIAL EA REPL	additional information. Prior authorization is required for billed charges greater than \$500. Reference policies for	HHO-DE-MP-1246 Home Dialysis Equipment and Supplies HHO-DE-MP-1246 Home Dialysis Equipment and Supplies	
E1530		additional information.		

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E1560	BLD LEAK DETECTOR HEMODIAL EA REPL	Prior authorization is required for billed charges greater than \$500. Reference policies for additional information.	HHO-DE-MP-1246 Home Dialysis Equipment and Supplies	
E1570	ADJUSTABLE CHAIR FOR ESRD PATIENTS	Prior authorization is required for billed charges greater than \$500. Reference policies for additional information.	HHO-DE-MP-1246 Home Dialysis Equipment and Supplies	
E1575	TRNSDUCR PRTCTR/BARR HEMODIAL SZ-10	Prior authorization is required for billed charges greater than \$500. Reference policies for additional information.	HHO-DE-MP-1246 Home Dialysis Equipment and Supplies	
E1580	UNIPUNCTURE CONTROL SYSTEM HEMODIAL	Prior authorization is required for billed charges greater than \$500. Reference policies for additional information.	HHO-DE-MP-1246 Home Dialysis Equipment and Supplies	
E1590	HEMODIALYSIS MACHINE	Prior authorization is required for billed charges greater than \$500. Reference policies for additional information.	HHO-DE-MP-1246 Home Dialysis Equipment and Supplies	
E1592	AUTO INTERMIT PERITON DIALYSIS SYS	Prior authorization is required for billed charges greater than \$500. Reference policies for additional information.	HHO-DE-MP-1246 Home Dialysis Equipment and Supplies	
E1594	CYCLR DIALYSIS MACH PERITON DIALYS	Prior authorization is required for billed charges greater than \$500. Reference policies for additional information.	HHO-DE-MP-1246 Home Dialysis Equipment and Supplies	
E1600	DEL &OR INSTL CHARGES HEMODIAL EQP	Prior authorization is required for billed charges greater than \$500. Reference policies for additional information.	HHO-DE-MP-1246 Home Dialysis Equipment and Supplies	
E1610	RVRS OSMOSIS H20 PURIF SYS HEMODIAL	Prior authorization is required for billed charges greater than \$500. Reference policies for additional information.	HHO-DE-MP-1246 Home Dialysis Equipment and Supplies	
E1615	DEIONIZER H2O PURIF SYS HEMODIAL	Prior authorization is required for billed charges greater than \$500. Reference policies for additional information.	HHO-DE-MP-1246 Home Dialysis Equipment and Supplies	
E1620	BLOOD PUMP HEMODIALYSIS REPLACEMENT	Prior authorization is required for billed charges greater than \$500. Reference policies for additional information.	HHO-DE-MP-1246 Home Dialysis Equipment and Supplies	
E1625	WATER SOFTENING SYSTEM HEMODIALYSIS	Prior authorization is required for billed charges greater than \$500. Reference policies for additional information.	HHO-DE-MP-1246 Home Dialysis Equipment and Supplies	
E1630	RECIPROCAT PERITON DIALYSIS SYSTEM	Prior authorization is required for billed charges greater than \$500. Reference policies for additional information.	HHO-DE-MP-1246 Home Dialysis Equipment and Supplies	
E1632	WEARABLE ARTIFICIAL KIDNEY EACH	Prior authorization is required when the billed charges are greater than \$500. Reference policies for additional information.	HHO-DE-MP-1246 Home Dialysis Equipment and Supplies	
E1634	PERITONEAL DIALYSIS CLAMPS EACH	Prior authorization is required for billed charges greater than \$500. Reference policies for additional information.	HHO-DE-MP-1246 Home Dialysis Equipment and Supplies	
E1635	COMPACT TRAVEL HEMODIALYZER SYSTEM	Prior authorization is required for billed charges greater than \$500. Reference policies for additional information.	HHO-DE-MP-1246 Home Dialysis Equipment and Supplies	
E1636	SORBENT CARTRIDGES HEMODIAL PER 10	Prior authorization is required for billed charges greater than \$500. Reference policies for additional information.	HHO-DE-MP-1246 Home Dialysis Equipment and Supplies	
E1637	HEMOSTATS EACH	Prior authorization is required when the billed charges are greater than \$500.		
E1639	SCALE EACH	Prior authorization is required when the billed charges are greater than \$500.		
E1699	DIALYSIS EQUIPMENT NOS	Prior authorization is required for billed charges greater than \$500.		
E1700	JAW MOTION REHABILITATION SYSTEM	Prior authorization is required when the billed charges are greater than \$500.		
E1701	REPL CUSHNS JAW MOT REHAB SYS PKG 6	Prior authorization is required when the billed charges are greater than \$500.		
E1702	REPL MSR SCLS JAW MOT REHAB SYS 200	Prior authorization is required when the billed charges are greater than \$500.		
E1800 E1801	DYN ADJUSTABLE ELB EXT/FLX DEVC	Prior authorization is required when the billed charges are greater than \$500.		
E1801 E1802	STATIC PROGRESSV STRETCH ELBOW DEVC	Prior authorization is required when the billed charges are greater than \$500.		
E1802 E1805	DYN ADJUSTBL FORARM PRON/SUPIN DEVC DYN ADJUSTABLE WRIST EXT/FLX DEVC	Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500.		
E1805	STATIC PROGRESSV STRETCH WRIST DEVC	Prior authorization is required when the billed charges are greater than \$500.		
E1800 E1810	DYN ADJUSTABLE KNEE EXT/FLX DEVC	Prior authorization is required when the billed charges are greater than \$500.		
E1810	STATIC PROGRESSV STRETCH KNEE DEVC	Prior authorization is required when the billed charges are greater than \$500.		
E1812	DYN KNEE EXT/FLEX DEVC RESIST CNTRL	Prior authorization is required when the billed charges are greater than \$500.		
E1815	DYN ADJ ANK EXT/FLX DVC W/INTF MATL	Prior authorization is required when the billed charges are greater than \$500.		
E1816	STATIC PROGRESSV STRETCH ANKLE DEVC	Prior authorization is required when the billed charges are greater than \$500.		
E1818	STATIC PROGRSV STRETCH FOREARM DEVC	Prior authorization is required when the billed charges are greater than \$500.		
E1820	REPL SFT INTERFCE MATL DYN EXT/FLX	Prior authorization is required when the billed charges are greater than \$500.		
E1821	REPL SFT INTERFCE MATL/CUFF BI-DIR	Prior authorization is required when the billed charges are greater than \$500.		
E1825	DYN ADJUSTABLE FINGER EXT/FLX DEVC	Prior authorization is required when the billed charges are greater than \$500.		
E1830	DYN ADJUSTABLE TOE EXT/FLX DEVC	Prior authorization is required when the billed charges are greater than \$500.		
E1831	STATIC PROGRESSIVE STRETCH TOE DEVC	Prior authorization is required when the billed charges are greater than \$500.		
E1840 E1841	DYN ADJUST SHLDR FLX/ABDUCT/ROT DVC STATIC PROGRS STRETCH SHOULDER DEVC	Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500.		
E1841 E1902	STATIC PROGRS STRETCH SHOULDER DEVC CMNCT BD NON-ELEC AUG/ALTERNTV DEVC	Prior authorization is required when the billed charges are greater than 5500. Prior authorization is required for billed charges greater than \$500. Reference policies for additional information.	HHO-DE-MP-1077 Speech Generating Devices	
	GASTR SUCTN PUMP HOME MODEL ELEC	Prior authorization is required when the billed charges are greater than \$500.		
F2000		Prior authorization is required when the billed charges are greater than \$500.		
E2000 E2100	BLD GLU MON INTEGRT VOICE SYNTHESZR			
E2100	BLD GLU MON INTEGRT VOICE SYNTHESZR BLD GLU MON INTGRT LANCING/BLD SAMP			
E2100 E2101	BLD GLU MON INTGRT LANCING/BLD SAMP	Prior authorization is required when the billed charges are greater than \$500.		
E2100	BLD GLU MON INTGRT LANCING/BLD SAMP ADJUNCTIVE CONT GLUCOSE MON/RCVR	Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500.		
E2100 E2101 E2102	BLD GLU MON INTGRT LANCING/BLD SAMP	Prior authorization is required when the billed charges are greater than \$500.	Image: Constraint of the second sec	
E2100 E2101 E2102 E2103	BLD GLU MON INTGRT LANCING/BLD SAMP ADJUNCTIVE CONT GLUCOSE MON/RCVR Non-adjunctive, non-implanted continuous glucose monitor or receiver	Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500.		
E2100 E2101 E2102 E2103 E2120	BLD GLU MON INTGRT LANCING/BLD SAMP ADJUNCTIVE CONT GLUCOSE MON/RCVR Non-adjunctive, non-implanted continuous glucose monitor or receiver PULSE GEN SYS TYMPANIC TX INNR EAR	Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500.		

E2203 MNL WC ACSS SEAT DEPTH 20 < 11 IN	
E2205 MNLWC HANDRIM W/O PROJ REPL EACH Prior authorization is required when the billed charges are greater than \$500. E2206 MANL WC AC WL ASM CMPL REPL ONLY EA Prior authorization is required when the billed charges are greater than \$500. E2207 WHLCHAIR ACCESS CRUTCH& CANE HLDR EA Prior authorization is required when the billed charges are greater than \$500. E2208 WHECHAIR ACCESS CRUTCH& CANE HLDR EA Prior authorization is required when the billed charges are greater than \$500. E2209 ARM TROUGH W/WO HAND SUPPORT EACH Prior authorization is required when the billed charges are greater than \$500.	
E2206 MANLWC AC WL ASM CMPL REPL ONLY EA Prior authorization is required when the billed charges are greater than \$500. E2207 WHICHAIR ACCESS CRUTCH& CANE HLDR EA Prior authorization is required when the billed charges are greater than \$500. E2208 WHEELCHAIR ACCESS CYLTANK CARR EA Prior authorization is required when the billed charges are greater than \$500. E2209 ARM TROUGH W/WO HAND SUPPORT EACH Prior authorization is required when the billed charges are greater than \$500.	
E2207 WHICHAIR ACCESS CRUTCH&CANE HLDR EA Prior authorization is required when the billed charges are greater than \$500. E2208 WHEELCHAIR ACCESS CYLTANK CARE EA Prior authorization is required when the billed charges are greater than \$500. E2209 ARM TROUGH W/WO HAND SUPPORT EACH Prior authorization is required when the billed charges are greater than \$500.	
E2208 WHEELCHAIR ACCESS CYL TANK CARR EA Prior authorization is required when the billed charges are greater than \$500. E2209 ARM TROUGH W/WO HAND SUPPORT EACH Prior authorization is required when the billed charges are greater than \$500.	
E2209 ARM TROUGH W/WO HAND SUPPORT EACH Prior authorization is required when the billed charges are greater than \$500.	
E2210 WCACESS BEARINGS ANY TYPE REPLEA Prior authorization is required when the billed charges are greater than \$500.	
E2211 MNL WC ACESS PNEUMAT PROPULSN TIRE Prior authorization is required when the billed charges are greater than \$500.	
E2212 MNL WC TUBE PNEUMAT PROPULSION TIRE Prior authorization is required when the billed charges are greater than \$500.	
E2213 MNL WC INSRT PNEUMAT PROPULSN TIRE Prior authorization is required when the billed charges are greater than \$500.	
E2214 MNL WC ACCESS PNEUMAT CASTER TIRE Prior authorization is required when the billed charges are greater than \$500.	
E2215 MNL WC ACSS TUBE PNEUMAT CASTR TIRE Prior authorization is required when the billed charges are greater than \$500.	
E2216 MNL WCACSS FOAM FILL PROPULSN TIRE Prior authorization is required when the billed charges are greater than \$500.	
E2217 MNLWCACCSS FOAM FILL CASTER TIRE Prior authorization is required when the billed charges are greater than \$500.	
E2218 MNLWCACCSS FOAM PROPULSION TIRE Prior authorization is required when the billed charges are greater than \$500.	
E2219 MNLWCACSS FOAM CASTER TIRE ANY SZ Prior authorization is required when the billed charges are greater than 5500.	
E2220 MINUK ACSLIP PROFISZ RPLOVINY EA Prior automationary equived when the billed charges are greater than \$500.	
E220 MM WCACSDO TRIS SZ REPLONY FA Prior automation required when the billed charges are greater than 5500.	
E2222 MINUMCACSLOCTINE UMLSZ RPLE Prior automization is required when the billed charges are greater than 5500.	
E2222 MIN. WCACSUCTINE I WHILS2 KPLE Prior autorization is required when the billed charges are greater than \$500. E2224 MIN. WCAC P WHILSC ITS ZR PLONE Prior autorization is required when the billed charges are greater than \$500.	
E225 MNLWCASTR WHL EXCD TIRE REPL Prior authorization is required when the billed charges are greater than \$500.	
E2226 MNL WC ACSS CASTR FOR KEPL ONLY Prior authorization is required when the billed charges are greater than \$500.	
E2227 MML WC GEAR RED DRIVE WHEEL EACH Prior authorization is required when the billed charges are greater than \$500.	
E2228 MNLWC WHL BRAKE SYS&LOCK COMPLEA Prior authorization is required when the billed charges are greater than \$500.	
E2230 MNL WHEELCHAIR ACCESS MNL STAND SYS Prior authorization is required when the billed charges are greater than \$500.	
E2231 MNLWC ACCESS SOLID SEAT SUPP BASE Prior authorization is required when the billed charges are greater than \$500.	
E2291 BACK PLANR PED WC FIX ATTCH HARDWRE Prior authorization is required when the billed charges are greater than \$500.	
E2292 SEAT PLANR PED WC FIX ATTCH HARDWRE Prior authorization is required when the billed charges are greater than \$500.	
E2293 BACK CONTRD PED WC ATTCH HARDWARE Prior authorization is required when the billed charges are greater than \$500.	
E2294 SEAT CONTRD PED WC ATTCH HARDWARE Prior authorization is required when the billed charges are greater than \$500.	
E2295 MNL WC ACCESS PED SIZE WC SEAT FRME Prior authorization is required when the billed charges are greater than \$500.	
E2300 WCACC PWR SEAT ELEV SYS ANY TYPE Prior authorization is required when the billed charges are greater than \$500.	
E2301 WHEELCHAIR ACC PWR STND SYS ANY TYP Prior authorization is required when the billed charges are greater than \$500.	
E2310 PWR WC ACSS ELEC CNCT BETWN WC CNTR Prior authorization is required when the billed charges are greater than \$500.	
E2311 PWR WC ACSS ELEC CNCT BETWN WC CNTR Prior authorization is required when the billed charges are greater than \$500.	
E2312 POWER WC HAND/CHIN CONTRL INTERFACE Prior authorization is required when the billed charges are greater than \$500.	
E2313 POWER AC HARNESS UPGRD EXP CONTRLLR Prior authorization is required when the billed charges are greater than \$500.	
E2321 PWR WC ACSS HND CNTRL NO PRPRTNL Prior authorization is required when the billed charges are greater than \$500.	
E2322 PWR WC ACSS MX MECH SWTCH NOPRPRTNL Prior authorization is required when the billed charges are greater than \$500.	
E2323 PWR WC ACSS SPCLTY JOYSTCK HND PRFB Prior authorization is required when the billed charges are greater than \$500.	
E2324 PWR WC ACSS CHIN CUP CHIN CNTRL INT Prior authorization is required when the billed charges are greater than \$500.	
E2325 PWR WC ACSS SIP&PUFF NONPRPRTNAL Prior authorization is required when the billed charges are greater than \$500.	
E2326 PWR WC ACSS BREATH TUBE KIT SIP& PUF Prior authorization is required when the billed charges are greater than \$500.	
E2327 PWR WC ACSS HEAD CNTRL MECH PRPRTNL Prior authorization is required when the billed charges are greater than \$500.	
E328 PWR WC ACSS HEAD/EXT ELEC PRPRTNL Prior authorization is required when the billed charges are greater than \$500.	
E2329 PWRWCACSS CNTCSWTCH NOPRRRTNL Prior authorization is required when the billed charges are greater than \$500.	
E2330 PWR WC ACCSS PROX SWTCH NOPROPRTNL Prior authorization is required when the billed charges are greater than \$500.	
E2331 PWR WCACSS ATDANT CNTRL PROPRTNAL Prior authorization is required when the billed charges are greater than \$500.	
E2340 POWER WCNONSTAND SEAT WD 20-23 IN Prior authorization is required when the billed charges are greater than 5500.	
E2341 PWK ACKS NONSTO SEAT W2 4271N Prior automation is required when the billed charges are greater than 5500.	
E2342 PWW/CNDNSTD SEAT DEPTH 20/21 IN Prior automation required when the billed charges are greater than \$500.	
E342 PWK/CKONSTO SCAT DEFT 122 SIN Prior automation sequred when the billed charges are greater than \$500.	
E2343 PWW/Cholor Start Der Mitzels W Prior autorization is required when the billed charges are greater than 5500. E2351 PWW/Chols E0 Set 00 PSPCH GEN DEVC Prior autorization is required when the billed charges are greater than 5500.	
E331 PWWWCAB31EC0F3F04CH0EVC PHOF adultation is equired when the billed charges are greater than 5500. E2358 PWWWCAB31EC0F3F04CH0EVC Phofe adultation is equired when the billed charges are greater than 5500.	
E2356 PWW/WCGRP34R04SALEDLABATEA Prior additionaris equired when the billed charges are greater than 5500. E2359 PWW/CGRP34R04SALEDLABATEA Prior additionaris equired when the billed charges are greater than 5500.	
E2359 PWWWCdwr 34 SALED da Art FA Prior addroifzadon'r sequired when the Dired charges are greater than 5500. E2360 PWRWCdxS 22 PK NON-SKALED BATRY Prior addroifzadon'r sequired when the Dired charges are greater than 5500.	
E2360 PWW WCACS 22 WF NOV#SEALED BATTRY Prior authorization is required when the billed charges are greater than \$500. E2361 PWR WCACS 22 VF SALED LEAD BATTRY Prior authorization is required when the billed charges are greater than \$500.	
E2361 PWR WCACSS 22NF SEALED LEAD BAT INF Prior authorization is required when the billed charges are greater than \$500. E2362 PWR WCACSS GRP 24 NON-SEALED BATT Prior authorization is required when the billed charges are greater than \$500.	
E2363 PWR WC ACSS GRP 24 SEALED BATTRY Prior authorization is required when the billed charges are greater than \$500.	
E2364 PWR WC ACSS U-1 NON-SEALED BATTRY Prior authorization is required when the billed charges are greater than \$500.	
E2365 PWR WC ACSS U-1 SEALED BATTRY Prior authorization is required when the billed charges are greater than \$500.	
E2366 PWR WC ACGS BATTRY CHARGER 1 MODE Prior authorization is required when the billed charges are greater than \$500.	
E2367 PWR WC ACSS BATTRY CHARGER DUL MODE Prior authorization is required when the billed charges are greater than \$500.	
E2368 PWR WC CMPNT DR WHEEL MTR REPL ONLY Prior authorization is required when the billed charges are greater than \$500.	
E2369 PWR WC CMPNNT DR WHL GR BX RPL ONLY Prior authorization is required when the billed charges are greater than \$500.	
E2370 PWC CMP INT DR WHL MTR&GB CMB RPL Prior authorization is required when the billed charges are greater than \$500.	
E2371 PWR WC GRP 27 SEALED LEAD ACID BATT Prior authorization is required when the billed charges are greater than \$500.	l

E2372	PWR WC GRP 27 NONSEAL LED ACID BATT	Prior authorization is required when the billed charges are greater than \$500.		
E2373	PWR WC MINI COMPACT REMOTE JOYSTICK	Prior authorization is required when the billed charges are greater than \$500.		
E2374	PWR WC STANDRD REMOTE JOYSTICK REPL	Prior authorization is required when the billed charges are greater than \$500.		
E2375	PWR WC NONEXPANDBLE CONTROLLER REPL	Prior authorization is required when the billed charges are greater than \$500.		
E2376	PWR WC EXPANDABLE CONTROLLER REPL	Prior authorization is required when the billed charges are greater than \$500.		
E2377	PWR WC EXPANDBL CONTROLLER UPGRADE	Prior authorization is required when the billed charges are greater than \$500.		
E2378	POWER WC CMPNT ACTUATOR REPL ONLY	Prior authorization is required when the billed charges are greater than \$500.		
E2381	PWR WC PNEUMATIC WHEEL TIRE REPLEA	Prior authorization is required when the billed charges are greater than \$500.		
E2382	PWR WC TUBE WHEEL TIRE REPLEA	Prior authorization is required when the billed charges are greater than \$500.		
E2383	PWR WCINSERT WHEEL TIRE REPLEA	Prior authorization is required when the billed charges are greater than \$500.		
E2384	PWR WC PNEUMATIC CASTR TIRE REPLEA	Prior authorization is required when the billed charges are greater than \$500.		
E2385	PWR WC TUBE CASTER TIRE REPLEA	Prior authorization is required when the billed charges are greater than \$500.		
E2386	PWR WC FOAM FILL WHEEL TIRE REPLEA	Prior authorization is required when the billed charges are greater than \$500.		
E2387	PWR WC FOAM FILL CASTR TIRE REPL EA	Prior authorization is required when the billed charges are greater than \$500.		
E2388	PWR WC FOAM WHEEL TIRE REPLONLY EA	Prior authorization is required when the billed charges are greater than \$500.		
E2389	PWR WC FORM CASTER TIRE REPLEACH	Prior authorization is required when the billed charges are greater than \$500.		
E2390	PWR WC SOLID WHEEL TIRE REPLEACH	Prior authorization is required when the billed charges are greater than \$500.		
E2390	PWR WC SOLID CASTER TIRE REPLEACH	Prior authorization is required when the billed charges are greater than \$500.		
E2391	PWR WC S CASTR TIRE INTEGRT REPLEA	Prior authorization is required when the billed charges are greater than \$500.		
E2392	PWR WC 3 CASTRITILE INTEGRITILE REPL	Prior authorization is required when the billed charges are greater than \$500.		
E2394 E2395	PWR WC DRIVE WHEEL EXCL TIRE REPL PWR WC CASTER WHEEL EXCL TIRE REPL			
		Prior authorization is required when the billed charges are greater than \$500.		
E2396	PWR WC CASTER FORK REPL ONLY EACH	Prior authorization is required when the billed charges are greater than \$500.		
E2397	POWER WC LITHIUM BASED BATTERY EACH	Prior authorization is required when the billed charges are greater than \$500.		
E2398	WHEELCHAIR AC DYN POS HARDWARE BACK	Prior authorization is required when the billed charges are greater than \$500.		
E2402	Negative pressure wound therapy electrical pump, stationary or portable	Prior authorization is required for billed charges greater than \$500. Reference policies for additional information.	HHO-DE-MP-1039 Negative Pressure Wound Therapy	
E2500	SPEECH GEN DEV DIGTIZD =8 MINS REC</td <td>Prior authorization is required for billed charges greater than \$500. Reference policies for additional information.</td> <td>HHO-DE-MP-1077 Speech Generating Devices</td> <td></td>	Prior authorization is required for billed charges greater than \$500. Reference policies for additional information.	HHO-DE-MP-1077 Speech Generating Devices	
E2502	SPCH GEN DEVC DGTZD>8<= 20 MINS REC	Prior authorization is required for billed charges greater than \$500. Reference policies for additional information.	HHO-DE-MP-1077 Speech Generating Devices	
E2504	SPCH GEN DEVC DGTZD>20 =40 MIN REC</td <td>Prior authorization is required for billed charges greater than \$500. Reference policies for additional information.</td> <td>HHO-DE-MP-1077 Speech Generating Devices</td> <td></td>	Prior authorization is required for billed charges greater than \$500. Reference policies for additional information.	HHO-DE-MP-1077 Speech Generating Devices	
E2506	SPCH GEN DEVC DIGTIZD>40 MINS REC	Prior authorization is required for billed charges greater than \$500. Reference policies for additional information.	HHO-DE-MP-1077 Speech Generating Devices	
E2508	SPCH GEN DEVC SYNTHSIZD REQ MESS	Prior authorization is required for billed charges greater than \$500. Reference policies for additional information.	HHO-DE-MP-1077 Speech Generating Devices	
E2510	SPCH GEN DVC SYNTHSIZD MX METH MESS	Prior authorization is required for billed charges greater than \$500. Reference policies for additional information.	HHO-DE-MP-1077 Speech Generating Devices	
E2511	SPEECH GENERATING SOFTWARE PROGRAM	Prior authorization is required for billed charges greater than \$500. Reference policies for additional information.	HHO-DE-MP-1077 Speech Generating Devices	
E2512	ACSS SPCH GEN DEVICE MOUNTING SYS	Prior authorization is required for billed charges greater than \$500. Reference policies for additional information.	HHO-DE-MP-1077 Speech Generating Devices	
E2599	ACCESS SPEECH GENERATING DEVICE NOC	Prior authorization is required for billed charges greater than \$500. Reference policies for additional information.	HHO-DE-MP-1077 Speech Generating Devices	
E2601	GEN WC SEAT CUSHN WIDTH < 22 DEPTH	Prior authorization is required when the billed charges are greater than \$500.		
E2602	GEN WC SEAT CSHN WDTH 22 IN/GT DPTH	Prior authorization is required when the billed charges are greater than \$500.		
E2603	SKN PROTCT WC SEAT WDTH<22IN DPTH	Prior authorization is required when the billed charges are greater than \$500.		
E2604	SKN PROTECT WC SEAT WDTH 22 IN/GT	Prior authorization is required when the billed charges are greater than \$500.		
E2605	PSTN WC SEAT CUSHN WIDTH < 22 DEPTH	Prior authorization is required when the billed charges are greater than \$500.		
E2606	PSTN WC SEAT CSHN WDTH 22IN/GT DPTH	Prior authorization is required when the billed charges are greater than \$500.		
E2607	SKN PROTCT&PSTN WC SEAT WDTH <22IN	Prior authorization is required when the billed charges are greater than \$500.		
E2608	SKN PROTCT&PSTN WC SEAT WDTH 22IN/>	Prior authorization is required when the billed charges are greater than \$500.		
E2609	CUSTOM FAB WHICHAIR SEAT CUSHN SIZE	Prior authorization is required when the billed charges are greater than \$500.	1	
E2610	WHEELCHAIR SEAT CUSHION POWERED	Prior authorization is required when the billed charges are greater than \$500.	1	
E2611	GEN WC BACK CUSHN WIDTH < 22 IN HT	Prior authorization is required when the billed charges are greater than \$500.		
E2612	GEN WC BACK CUSHN WIDTH 22 IN/GT HT	Prior authorization is required when the billed charges are greater than \$500.	1	
E2613	PSTN WC BACK CUSHN POST WDTH <22 IN	Prior authorization is required when the billed charges are greater than \$500.		
E2614	PSTN WC BACK CUSHN POST WD 22 IN/>	Prior authorization is required when the billed charges are greater than \$500.		
E2615	PSTN WC BACK CUSHN POSTLAT WD<22 IN	Prior authorization is required when the billed charges are greater than \$500.		
E2616	PSTN WC BACK CUSH POSTLAT WD 221N/>	Prior authorization is required when the billed charges are greater than \$500.		
E2617	CSTM FAB WC BACK CUSHION ANY SIZE	Prior authorization is required when the billed charges are greater than \$500.		
E2619	REPL COVER WC SEAT/BACK CUSHN EA	Prior authorization is required when the billed charges are greater than \$500.		
E2620	PSTN WC BACK CUSHN PLANAR WD <22 IN	Prior authorization is required when the billed charges are greater than \$500.		
E2621	PSTN WC BACK CUSHN PLANAR WD 22IN/>	Prior authorization is required when the billed charges are greater than \$500.		
E2622	SKIN PROTECT WC CUSH WIDTH <22 IN	Prior authorization is required when the billed charges are greater than \$500.		
E2623	SKIN PROTECT WC CUSH WIDTH 22 IN/>	Prior authorization is required when the billed charges are greater than \$500.		
E2624	SKIN HOTECH WE COSH WIDTIZZ 1107	Prior authorization is required when the billed charges are greater than \$500.		
E2625	SKIN PROTECT&POSITION WE COSH WD <22 SKIN PROTECT&POSITION WE CUSH W 22/>	Prior authorization is required when the billed charges are greater than \$500.		
E2626	WC SHLDR ELB MOBL ARM SUPP ADJUSTBL	Prior authorization is required when the billed charges are greater than \$500.		
12020	WC SHEEK EED WODE ANW SUFF ADJUSTBE	automation is required when the billed charges are greater than \$500.		

E2627	WC SHLDR ELB M SUPP ADJUSTBL RANCHO	Prior authorization is required when the billed charges are greater than \$500.		
E2628	WC SHLDR ELB MOBIL SUPP RECLINING	Prior authorization is required when the billed charges are greater than \$500.		
E2629	WC SHLDR ELB M SUPP FRICTN ARM SUPP	Prior authorization is required when the billed charges are greater than \$500.		
E2630	WC SHLDR ELB M SUP MONOSUSP ARM HND	Prior authorization is required when the billed charges are greater than \$500.		
E2631	WC ADD MOBIL ARM SUPP ELEV PROX ARM	Prior authorization is required when the billed charges are greater than \$500.		
E2632	WC ADD MOBL SUP OFFSET/LAT RCKR ARM	Prior authorization is required when the billed charges are greater than \$500.		
E2633	WC ACSS ADD MOBIL ARM SUPP SUPINATR	Prior authorization is required when the billed charges are greater than \$500.		
E8000	GAIT TRAINER PED SZ POST SUPP	Prior authorization is required when the billed charges are greater than \$500.		
E8001	GAIT TRAINER PED SZ UPRIGHT SUPP	Prior authorization is required when the billed charges are greater than \$500.		
E8002	GAIT TRAINER PED SZ ANT SUPP	Prior authorization is required when the billed charges are greater than \$500.		
	Psychotherapy for crisis furnished in an applicable site of service (any place of service at			
G0017	which the non-facility rate for psychotherapy for crisis services applies, other than the			
	office setting); first 60 minutes			
60104	Advantation of the first state of the state	Prior authorization is required for members under the age of 45. Reference policies for additional	HHO-DE-MP-1007 Colorectal Cancer Screening	
G0104	Colorectal cancer screening; flexible sigmoidoscopy	information.	HHO-DE-MP-1007 Colorectal Cancer Screening	
G0105	Colorectal cancer screening; colonoscopy on individual at high risk	Prior authorization is required for members under the age of 45. Reference policies for additional information.	HHO-DE-MP-1007 Colorectal Cancer Screening	
	Colorectal cancer screening; alternative to G0104, screening sigmoidoscopy, barium	Prior authorization is required for members under the age of 45. Reference policies for additional		
G0106	enema	information.	HHO-DE-MP-1007 Colorectal Cancer Screening	
G0120	Colorectal cancer screening; alternative to G0105, screening colonoscopy, barium enema	Prior authorization is required for members under the age of 45. Reference policies for additional information.	HHO-DE-MP-1007 Colorectal Cancer Screening	
G0121	olorectal cancer screening; colonoscopy on individual not meeting criteria for high risk	Prior authorization is required for members under the age of 45. Reference policies for additional information.	HHO-DE-MP-1007 Colorectal Cancer Screening	
G0239	Therapeutic procedures to improve respiratory function or increase strength or endurance of respiratory muscles, two or more individuals (includes monitoring)	Prior authorization is required. Reference policies for additional information.	HHO-DE-RP-1013 Therapy Services	
	Injection procedure for sacroiliac joint; provision of anesthetic, steroid and/or other			Prior authorization is managed by
G0260	therapeutic agent, with or without arthrography	Prior authorization is managed by EviCore.		EviCore.
	Medical nutrition therapy; reassessment and subsequent intervention(s) following second			Evicore.
	referral in same year for change in diagnosis, medical condition or treatment regimen			
G0270	(including additional hours needed for renal disease), individual, face-to-face with the	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1133 Medical Nutrition Management Services	
	patient, each 15 minutes			
	Medical nutrition therapy, reassessment and subsequent intervention(s) following second			
	referral in same year for change in diagnosis, medical condition, or treatment regimen			
G0271	(including additional hours needed for renal disease), group (two or more individuals), each	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1133 Medical Nutrition Management Services	
	30 minutes			
	Electrical Stimulation, (unattended), To One Or More Areas, For Chronic Stage Iii And Stage			
	Iv Pressure Ulcers, Arterial Ulcers, Diabetic Ulcers and Venous Stasis Ulcers Not			
G0281	Demonstrating Measurable Signs Of Healing After 30 Days Of Conventional Care, As Part	Prior authorization is required. Reference policies for additional information.	HHO-DE-RP-1013 Therapy Services	
	Of A Therapy Plan To Care			
60220	Colorectal cancer screening; fecal occult blood test, immunoassay, one to three	Prior authorization is required for members under the age of 45. Reference policies for additional		
G0328	simultaneous determinations	information.	HHO-DE-MP-1007 Colorectal Cancer Screening	
G0341	Percutaneous islet cell transplant, includes portal vein catheterization and infusion	Prior authorization is required.		
G0452	Molecular pathology procedure; physician interpretation and report	Prior authorization is required.		
	Autologous platelet rich plasma for nondiabetic chronic wounds/ulcers, including		HHO-DE-MP-1132 Skin Replacement Therapy For Chronic Non	
G0460	phlebotomy, centrifugation and all other preparatory procedures, administration and	Prior authorization is required. Reference policies for additional information.	healing Wounds in The Outpatient Setting	
	dressings, per treatment		hearing wounds in the Outpatient setting	
G6001	Ultrasonic guidance for placement of radiation therapy fields	Prior authorization is required for conditions other than cancer.		
G6002	Stereoscopic x-ray guidance for localization of target volume for the delivery of radiation	Prior authorization is required for conditions other than concer		
00002	therapy	Prior authorization is required for conditions other than cancer.		
G6003	Radiation treatment delivery, single treatment area, single port or parallel opposed ports, simple blocks or no blocks: up to 5 mev	Prior authorization is required for conditions other than cancer.		
G6004	Radiation treatment delivery, single treatment area, single port or parallel opposed ports, simple blocks or no blocks: 6-10 mev	Prior authorization is required for conditions other than cancer.		
G6005	Radiation treatment delivery, single treatment area, single port or parallel opposed ports,	Prior authorization is required for conditions other than cancer.		
	simple blocks or no blocks: 11-19 mev			
G6006	Radiation treatment delivery, single treatment area, single port or parallel opposed ports, simple blocks or no blocks; 20 mey or greater	Prior authorization is required for conditions other than cancer.		
	simple blocks or no blocks: 20 mev or greater Radiation treatment delivery, two separate treatment areas, three or more ports on a			
G6007	single treatment area, use of multiple blocks: up to 5 mev	Prior authorization is required for conditions other than cancer.		
G6008	Radiation treatment delivery, two separate treatment areas, three or more ports on a single treatment area, use of multiple blocks: 6-10 mev	Prior authorization is required for conditions other than cancer.		
G6009	Radiation treatment delivery, two separate treatment areas, three or more ports on a single treatment area, use of multiple blocks: 11-19 mev	Prior authorization is required for conditions other than cancer.		
G6010	Radiation treatment delivery, two separate treatment areas, three or more ports on a	Prior authorization is required for conditions other than cancer.		
	single treatment area, use of multiple blocks: 20 mev or greater	·		
G6011	Radiation treatment delivery, three or more separate treatment areas, custom blocking,	Prior authorization is required for conditions other than cancer.		
	tangential ports, wedges, rotational beam, compensators, electron beam; up to 5 mev	• • • • •		
1	Radiation treatment delivery, three or more separate treatment areas, custom blocking,	Prior authorization is required for conditions other than cancer.		
G6012	tangential ports, wedges, rotational beam, compensators, electron beam; 6-10 mev			
	tangential ports, wedges, rotational beam, compensators, electron beam; 6-10 mev Radiation treatment delivery, three or more separate treatment areas, custom blocking,			
G6012 G6013		Prior authorization is required for conditions other than cancer.		

G6014	Radiation treatment delivery, three or more separate treatment areas, custom blocking, tangential ports, wedges, rotational beam, compensators, electron beam; 20 mev or greater	Prior authorization is required for conditions other than cancer.		
G6015	Intensity modulated treatment delivery, single or multiple fields/arcs, via narrow spatially and temporally modulated beams, binary, dynamic MLC, per treatment session	Prior authorization is required.		
G6016	Compensator-based beam modulation treatment delivery of inverse planned treatment using three or more high resolution (milled or cast) compensator, convergent beam modulated fields, per treatment session	Prior authorization is required for conditions other than cancer.		
G6017	Intra-fraction localization and tracking of target or patient motion during delivery of radiation therapy (e.g., 3D positional tracking, gating, 3D surface tracking), each fraction of treatment	Prior authorization is required for conditions other than cancer.		
H0015	Alcohol and/or drug services; intensive outpatient (treatment program that operates at least 3 hours/day and at least 3 days/week and is based on an individualized treatment plan), including assessment, counseling; crisis intervention and activity therapies or education	A prior authorization is required. Members must have a behavorial health diagnosis.		
H0035	Mental health partial hospitalization, treatment, less than 24 hours	A prior authorization is required. Members must have a behavorial health diagnosis.		
H0046	Mental health services, not otherwise specified	Prior authorization is required.		
H0047	Alcohol and/or other drug abuse services, not otherwise specified	Prior authorization is required.		
H2034	Alcohol and/or drug abuse halfway house services, per diem	A prior authorization is required. Members must be 18 and older, with a behavioral health diagnosis.		
H2036	Alcohol and/or other drug treatment program, per diem	A prior authorization is required. Members must be 18 and older, with a behavioral health diagnosis.		
J0129	Injection, abatacept, 10 mg (code may be used for medicare when drug administered under the direct supervision of a physician, not for use when drug is self administered	Prior authorization is required.		
J0135	Injection, adalimumab, 20 mg	Prior authorization is required.		
J0172	Injection, aducanumab-avwa, 2 mg	Prior authorization is required.		
J0178	Injection, aflibercept, 1 mg	Prior authorization is required.		
J0180	Injection, agalsidase beta, 1 mg	Prior authorization is required.		
J0221	Injection, alglucosidase alfa, (lumizyme), 10 mg	Prior authorization is required.		
J0222	Injection, patisiran, 0.1 mg	Prior authorization is required.		
J0256	Injection, alpha 1 proteinase inhibitor (human), not otherwise specified, 10 mg	Prior authorization is required.		
J0257	Injection, alpha 1 proteinase inhibitor (human), (glassia), 10 mg	Prior authorization is required.		
J0490	Injection, belimumab, 10 mg	Prior authorization is required.		
J0517	Injection, benralizumab, 1 mg	Prior authorization is required.		
J0567	Injection, cerliponase alfa, 1 mg	Prior authorization is required.		
J0584 J0585	Injection, burosumab-twza, 1 mg Injection, onabotulinumtoxinA, 1 unit	Prior authorization is required. Prior authorization is required and medical necessity criteria must be met. Cosmetic procedures are a non-covered service. Reference policies for additional information.	HHO-DE-MP-1137 Hyperhidrosis	
J0586	Injection, abobotulinumtoxinA, 5 units	Prior authorization is required and medical necessity criteria must be met. Cosmetic procedures are a non-covered service.		
J0587	Injection, rimabotulinumtoxinB, 100 units	Prior authorization is required and medical necessity criteria must be met. Cosmetic procedures are a non-covered service. Reference policies for additional information.	HHO-DE-MP-1137 Hyperhidrosis	
J0588	Injection, incobotulinumtoxinA, 1 unit	Prior authorization is required and medical necessity criteria must be met. Cosmetic procedures are a non-covered service.		
10283	Injection, lanadelumab-flyo, 1 mg (code may be used for medicare when drug administered under direct supervision of a physician, not for use when drug is self- administered)	Prior authorization is required.		
J0596	Injection, c1 esterase inhibitor (recombinant), ruconest, 10 units	Prior authorization is required.		
J0597	Injection, c-1 esterase inhibitor (human), berinert, 10 units	Prior authorization is required.		
J0598	Injection, c-1 esterase inhibitor (human), cinryze, 10 units	Prior authorization is required.		
J0702	Injection, betamethasone acetate 3 mg and betamethasone sodium phosphate 3 mg	Prior authorization is required.		
J0717	Injection, certolizuma b pegol, 1 mg (code may be used for medicare when drug administered under the direct supervision of a physician, not for use when drug is self administered)	Prior authorization is required.		
J0775	Injection, collagenase, clostridium histolyticum, 0.01 mg	Prior authorization is required.		
J0791	Injection, crizanlizumab-tmca, 5 mg	Prior authorization is required.		
J0881	Injection, darbepoetin alfa, 1 microgram (non - esrd use)	Prior authorization is required.		
J0882	Injection, darbepoetin alfa, 1 microgram (for esrd on dialysis)	Prior authorization is required.		
10885	Injection, epoetin alfa, (for non-esrd use), 1000 units	Prior authorization is required.		
10007	Injection, epoetin beta, 1 microgram, (for esrd	Prior authorization is required.		
J0887	on dialysis) Injection, epoetin beta, 1 microgram, (for non			

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12402Injection, chloroprocaine hydrochloride (clorotekal), per 1 mgPrior authorization is required.Implement12503Injection, pegiprastin, excludes biosmilar, 0.5 mgPrior authorization is required.Implement12506Injection, pegifigrastin, excludes biosmilar, 0.5 mgPrior authorization is required.Implement12507Injection, pegifigrastin, excludes point 0.5 mgPrior authorization is required.Implement12508Injection, pegifigrastin, excludes point 0.5 mgPrior authorization is required.Implement12509Injection, pegificase, 1 mgPrior authorization is required.Implement12561Injection, ranibizumab, 0.1 mgPrior authorization is required.Implement12778Injection, ranibizumab, 0.1 mgPrior authorization is required.Implement12796Injection, romiplostin, 10 microgramsPrior authorization is required.Implement	J1745 J1786 J1812 J1814 J1823 J1931 J1941 J1950 J2182 J2212 J2323 J2326	(makena), 10 mg Injection, idursulfare, 1 mg Injection, inflixinab, excludes biosimilar, 10 mg Injection, imiglucerase, 10 units Insulin (fisp), per 5 units Insulin (fisp), per 5 units Injection, inebilizumab-cdor, 1 mg Injection, inebilizumab-cdor, 1 mg Injection, Inordiase, 0.1 mg Injection, Inordiase, 0.1 mg Injection, furosemide (furoscik), 20 mg Injection, furosemide (furoscik), 20 mg Injection, furosemide (furoscik), 20 mg Injection, neuroitage, 0.1 mg Injection, metylinaltrexone, 0.1 mg Injection, netalizumab, 1 mg Injection, netalizumab, 1 mg	Prior authorization is required.	
12503 Injection, pegaptanib sodium, 0.3 mg Prior authorization is required. 12506 Injection, pegifyrastim, excludes biosimilar, 0.5 mg Prior authorization is required. 12507 Injection, pegloticase, 1 mg Prior authorization is required. 12561 Injection, pegloticase, 1 mg Prior authorization is required. 12561 Injection, ranibizumab, 0.1 mg Prior authorization is required. 12778 Injection, ranibizumab, 0.1 mg Prior authorization is required. 12786 Injection, ranibizumab, 1 mg Prior authorization is required. 12796 Injection, romiplostim, 10 micrograms Prior authorization is required.	J1745 J1786 J1812 J1814 J1823 J1931 J1941 J1950 J2182 J2212 J2323 J2326 J2350	(makena), 10 mg Injection, idursulfase, 1 mg Injection, infliximab, excludes biosimilar, 10 mg Injection, imiglucerase, 10 units Insulin (fiasp), per 5 units Insulin (fiaymjev), per 5 units Insulin (hymiev), per 5 units Injection, inebilizumab-cdon, 1 mg Injection, inebilizumab-cdon, 1 mg Injection, neopilizumab, 20 mg Injection, furosemide (furoscik), 20 mg Injection, leuprolide acetate (for depot suspension), per 3-75 mg Injection, methylnaltrexone, 0.1 mg Injection, nusinersen, 0.1 mg Injection, nusinersen, 0.1 mg Injection, cusinersen, 0.1 mg	Prior authorization is required.	
12503Injection, pegaptanib sodium, 0.3 mgPrior authorization is required.Intercent perior12506Injection, pegifurstim, excludes biosimilar, 0.5 mgPrior authorization is required.Prior12507Injection, peglotase, 1 mgPrior authorization is required.Intercent peglotase, 1 mg12561Injection, peglotase, 1 mgPrior authorization is required.Intercent peglotase, 1 mg12778Injection, ranibizumab, 0 ngPrior authorization is required.Intercent peglotase, 1 mg12786Injection, ranibizumab, 1 mgPrior authorization is required.Intercent peglotase, 1 mg12796Injection, romiplostim, 10 microgramsPrior authorization is required.Intercent peglotase	J1745 J1786 J1812 J1814 J1823 J1931 J1941 J1950 J2182 J2212 J2323 J2326 J2350 J2357	(makena), 10 mg Injection, idursulfase, 1 mg Injection, infliximab, excludes biosimilar, 10 mg Injection, imiglucerase, 10 units Insulin (fiasp), per 5 units Insulin (fiaymjev), per 5 units Insulin (hymiev), per 5 units Injection, inebilizumab-cdon, 1 mg Injection, inebilizumab-cdon, 1 mg Injection, neopilizumab, 20 mg Injection, furosemide (furoscik), 20 mg Injection, leuprolide acetate (for depot suspension), per 3-75 mg Injection, methylnaltrexone, 0.1 mg Injection, nusinersen, 0.1 mg Injection, nusinersen, 0.1 mg Injection, cusinersen, 0.1 mg	Prior authorization is required.	
J2506 Injection, pegfigrastim, excludes biosimilar, 0.5 mg Prior authorization is required. J2507 Injection, pegloticase, 1 mg Prior authorization is required. J2561 Injection, pegloticase, 1 mg Prior authorization is required. J2778 Injection, ranibizumab, 0 mg Prior authorization is required. J2786 Injection, resizumab, 1 mg Prior authorization is required. J2796 Injection, resizumab, 1 mg compared Prior authorization is required.	J1745 J1786 J1812 J1814 J1823 J1931 J1941 J1950 J2182 J2212 J2323 J2326 J2350 J2357	(makena), 10 mg Injection, idursulfase, 1 mg Injection, inflixinab, excludes biosmilar, 10 mg Injection, imglucerase, 10 units Insulin (fiasp), per 5 units Insulin (fiasp), per 5 units Injection, Ineubilizumab-cdon, 1 mg Injection, Ineubilizumab-cdon, 1 mg Injection, Ineupolide acetate (for depot suspension), per 3.75 mg Injection, mepolizumab, 1 mg Injection, methylnaltrexone, 0.1 mg Injection, natalizumab, 1 mg Injection, natalizumab, 1 mg Injection, natalizumab, 1 mg Injection, noreitzumab, 1 mg	Prior authorization is required.	
125060.5 mgPrior authorization is required.12507Injection, pegloticase, 1 mgPrior authorization is required.Implement12561Injection, phenotabrital sodiu (sezaby), 1 mgPrior authorization is required.Implement12778Injection, ranibizumab, 0.1 mgPrior authorization is required.Implement12786Injection, ranibizumab, 1 mgPrior authorization is required.Implement12796Injection, romiplostim, 10 microgramsPrior authorization is required.Implement	J1745 J1786 J1812 J1814 J1823 J1931 J1941 J1950 J2182 J2212 J2323 J2326 J2350 J2357 J2402	(makena), 10 mg Injection, idursulfare, 1 mg Injection, inflixinab, excludes biosimilar, 10 mg Injection, imiglucerase, 10 units Insulin (fisp), per 5 units Insulin (fisp), per 5 units Injection, inebilizumab-cdor, 1 mg Injection, inebilizumab-cdor, 1 mg Injection, inebilizumab-cdor, 2 mg Injection, furosemide (furoscik), 20 mg Injection, furosemide (furoscik), 20 mg Injection, per 3.5 mg Injection, methylnaltrexone, 0.1 mg Injection, netsilizumab, 1 mg Injection, netsilizumab, 1 mg Injection, onsiersen, 0.1 mg Injection, netsilizumab, 1 mg Injection, oralizumab, 1 mg Injection, netsilizumab, 5 mg Injection, oralizumab, 5 mg	Prior authorization is required.	
12507 Injection, pegloticase, 1 mg Prior authorization is required. 12561 Injection, phenobarbital sodium (sezaby), 1 mg Prior authorization is required. 12778 Injection, ranibizumab, 0.1 mg Prior authorization is required. 12786 Injection, ranibizumab, 1 mg Prior authorization is required. 12796 Injection, romiplostim, 10 micrograms Prior authorization is required.	J1745 J1786 J1812 J1814 J1823 J1931 J1941 J1950 J2182 J2212 J2223 J2326 J2350 J2350 J2357 J2402 J2503	(makena), 10 mg Injection, idursulfase, 1 mg Injection, infihiranb, excludes biosimilar, 10 mg Injection, imiglucerase, 10 units Insulin (fiasp), per 5 units Insulin (fiasp), per 5 units Injection, inebilizumab-cdon, 1 mg Injection, inebilizumab-cdon, 1 mg Injection, ineroidase, 0.1 mg Injection, furosemide (furoscik), 20 mg Injection, furosemide (for depot suspension), per 3.75 mg Injection, methylnaltrexone, 0.1 mg Injection, methylnaltrexone, 0.1 mg Injection, oretizumab, 1 mg Injection, ocrelizumab, 1 mg Injection, ocrelizumab, 5 mg Injection, obrogorcaine hydrochloride (clorotekal), per 1 mg Injection, peg atranls odium, 0.3 mg	Prior authorization is required. Prior	
12561 Injection, phenobarbital sodium (sezaby), 1mg Prior authorization is required. 12778 Injection, ranibizumab, 0.1mg Prior authorization is required. 12786 Injection, resilizumab, 1mg Prior authorization is required. 12796 Injection, romipositim, 10 micrograms Prior authorization is required.	J1745 J1786 J1812 J1814 J1823 J1931 J1941 J1950 J2182 J2212 J2223 J2326 J2350 J2350 J2357 J2402 J2503	(makena), 10 mg Injection, idursulfase, 1 mg Injection, inflixinab, excludes biosimilar, 10 mg Injection, imglucerase, 10 units Insulin (fiasp), per 5 units Insulin (fiasp), per 5 units Injection, Ineubilizumab-cdon, 1 mg Injection, Ineubilizumab-cdon, 1 mg Injection, Ineuprolide acetate (for depot suspension), per 3.75 mg Injection, mepolizumab, 1 mg Injection, methylnaltrexone, 0.1 mg Injection, nusinersen, 0.3 mg Injection, nusinersen, 0.3 mg Injection, peralizumab, 1 mg Injection, nusinersen, 0.3 mg Injection, peralizumab, 1 mg Injection, per	Prior authorization is required. Prior	
12778 Injection, ranibizumab, 0.1 mg Prior authorization is required. 12786 Injection, reslizumab, 1 mg Prior authorization is required. 12796 Injection, romiplostim, 10 micrograms Prior authorization is required.	J1745 J1786 J1812 J1814 J1823 J1931 J1941 J1950 J2182 J2212 J2222 J2323 J2326 J2350 J2350 J2357 J2402 J2503 J2506	(makena), 10 mg Injection, idursulfare, 1 mg Injection, inflixinab, excludes biosimilar, 10 mg Injection, imiglucerase, 10 units Insulin (fisap), per 5 units Insulin (fisap), per 5 units Injection, inebilizumab-cdon, 1 mg Injection, inebilizumab-cdon, 1 mg Injection, ineolidase, 0.1 mg Injection, furosemide (furoscik), 20 mg Injection, furosemide (furoscik), 20 mg Injection, furosemide (furoscik), 20 mg Injection, furosemide (furoscik), 20 mg Injection, neuprolidase, 0.1 mg Injection, methylnaltrexone, 0.1 ng Injection, nusinersen, 0.1 mg Injection, nusinersen, 0.1 mg Injection, ocrelizumab, 1 mg Injection, oralizumab, 5 mg Injection, oralizumab, 5 mg Injection, chloroprocaine hydrochloride (clorotekal), per 1 mg Injection, perfiligrastim, excludes biosimilar, 0.5 mg	Prior authorization is required. Prior	
12786 Injection, resizumab, 1 mg Prior authorization is required. 12796 Injection, romiplostim, 10 micrograms Prior authorization is required.	J1745 J1786 J1812 J1814 J1823 J1931 J1941 J1950 J2182 J2212 J2323 J2326 J2350 J2350 J2350 J2350 J2506 J2507	(makena), 10 mg Injection, idursulfase, 1 mg Injection, infihiranb, excludes biosimilar, 10 mg Injection, imiglucerase, 10 units Insulin (lyunjev), per 5 units Insulin (lyunjev), per 5 units Injection, inebilizumab-cdon, 1 mg Injection, inebilizumab-cdon, 1 mg Injection, Iaronidase, 0.1 mg Injection, furosemide (furoscik), 20 mg Injection, furosemide (furoscik), 20 mg Injection, neuprolide acetate (for depot suspension), per 3.75 mg Injection, methylnaltrexone, 0.1 mg Injection, methylnaltrexone, 0.1 mg Injection, nethylnaltrexone, 0.1 mg Injection, ocrelizumab, 1 mg Injection, ocrelizumab, 5 mg Injection, onalizumab, 5 mg Injection, pegatanib sodium, 0.3 mg	Prior authorization is required. Prior	
12796 Injection, romiplostim, 10 micrograms Prior authorization is required.	J1745 J1786 J1812 J1814 J1823 J1931 J1941 J1950 J2182 J2212 J2323 J2326 J2350 J2357 J2402 J2503 J2506 J2507 J2561	(makena), 10 mg Injection, idursulfase, 1 mg Injection, infliximab, excludes biosimilar, 10 mg Injection, imglucerase, 10 units Insulin (fisap), per 5 units Insulin (fisap), per 5 units Injection, Ineubilizumab-cdon, 1 mg Injection, Ineubilizumab-cdon, 1 mg Injection, Ineuprolide acetate (for depot suspension), per 3.75 mg Injection, mepolizumab, 1 mg Injection, nusinersen, 0.1 mg Injection, nusinersen, 0.1 mg Injection, nusinersen, 0.1 mg Injection, norelizumab, 1 mg Injection, norelizumab, 1 mg Injection, nusinersen, 0.3 mg Injection, norelizumab, 1 mg Injection, negligrastim, sodium, 0.3 mg Injection, pegfligrastim, excludes biosimilar, 0.5 mg Injection, pegfligrastim, excludes biosimilar, 0.5 mg Injection, pegfligrastim, excludes biosimilar, 0.5 mg	Prior authorization is required. Prior	
	J1745 J1786 J1812 J1814 J1823 J1931 J1941 J1950 J2182 J2212 J2323 J2326 J2350 J2357 J2402 J2503 J2506 J2507 J2561 J2778	(makena), 10 mg Injection, idursulfare, 1 mg Injection, inflixinab, excludes biosimilar, 10 mg Injection, imiglucerase, 10 units Insulin (fisap), per 5 units Insulin (fisap), per 5 units Injection, Inebilizumab-cdon, 1 mg Injection, Inebilizumab-cdon, 1 mg Injection, Ineoindiase, 0.1 mg Injection, furosemide (furoscik), 20 mg Injection, furosemide (furoscik), 20 mg Injection, furosemide (furoscik), 20 mg Injection, neuprolide acetate (for depot suspension), per 3.75 mg Injection, methylnaltrexone, 0.1 mg Injection, nusinersen, 0.1 mg Injection, nusinersen, 0.1 mg Injection, orcelizumab, 1 mg Injection, orcelizumab, 1 mg Injection, organizumab, 5 mg Injection, organizumab, 5 mg Injection, pegaptanib sodium, 0.3 mg Injection, peglitastin, excludes biosimilar, 0.5 mg Injection, pegloticase, 1 mg Injection, pegloticase, 1 mg Injection, pegloticase, 1 mg	Prior authorization is required. Prior	
	J1745 J1786 J1812 J1814 J1823 J1931 J1941 J1950 J2182 J2212 J2323 J2326 J2350 J2350 J2357 J2402 J2503 J2506 J2507 J2506 J2507 J2561 J2778 J2786	(makena), 10 mg Injection, idursulfase, 1 mg Injection, infilixinab, excludes biosimilar, 10 mg Injection, imiglucerase, 10 units Insulin (lyunjev), per 5 units Insulin (lyunjev), per 5 units Insulin (lyunjev), per 5 units Injection, inebilizumab-cdon, 1 mg Injection, inebilizumab-cdon, 1 mg Injection, Iaronidase, 0.1 mg Injection, Iaronidase, 0.1 mg Injection, furosemide (furoscik), 20 mg Injection, furosemide (furoscik), 20 mg Injection, methylnaltrexone, 0.1 mg Injection, netalizumab, 1 mg Injection, netalizumab, 1 mg Injection, onsinersen, 0.1 mg Injection, onsilizumab, 5 mg Injection, pegaptanib sodium, 0.3 mg Injection, pegaptanib sodium, 0.3 mg Injection, pegolation (sezaby), 1 mg Injection, pelnobarbital sodium (sezaby), 1 mg Injection, nanibizumab, 0.1 mg Injection, resilizumab, 1 mg	Prior authorization is required. Prior	
J2840 Injection, sebelipase alfa, 1 mg Prior authorization is required.	J1745 J1786 J1812 J1814 J1823 J1931 J1941 J1950 J2182 J2212 J2323 J2326 J2350 J2350 J2503 J2506 J2507 J2506 J2507 J2561 J2778 J2778 J2786 J2796	(makena), 10 mg Injection, idursulfase, 1 mg Injection, infliximab, excludes biosimilar, 10 mg Injection, imglucerase, 10 units Insulin (fisap), per 5 units Insulin (fisap), per 5 units Injection, Inebilizumab-cdon, 1 mg Injection, Inebilizumab-cdon, 1 mg Injection, Ineopolizumab, 20 mg Injection, Ineopolizumab, 1 mg Injection, methylnaitrexone, 0.1 mg Injection, nethylnaitrexone, 0.1 mg Injection, nethylnaitrexone, 0.1 mg Injection, nethylnaitrexone, 0.1 mg Injection, nethylnaitrexone, 0.1 mg Injection, norelizumab, 1 mg Injection, norelizumab, 1 mg Injection, norelizumab, 5 mg Injection, norelizumab, 5 mg Injection, peglitarist, 5 mg Injection, peglitarist, 9 mg Injection, 1 mg Injection, 7 mibizumab, 0.1 mg Injection, 7 mibizumab, 1 mg Injection, 7 mibizumab, 1 mg	Prior authorization is required. Prior	

J2998	Plasminogen, human-tvmh (Ryplazim)	Prior authorization is required.		
J3032	Injection, eptinezumab-jjmr, 1 mg	Prior authorization is required.		
J3060	Injection, taliglucerase alfa, 10 units	Prior authorization is required.		
J3241	Injection, teprotumumab-trbw, 10 mg	Prior authorization is required.		
J3262	Injection, tocilizumab, 1 mg	Prior authorization is required.		
J3285	Injection, treprostinil, 1 mg	Prior authorization is required.		
J3357	Ustekinumab, for subcutaneous injection, 1 me	Prior authorization is required.		
J3358	Ustekinumab, for intravenous injection, 1 mg	Prior authorization is required.		
13358	Injection, vedolizumab, 1 mg	Prior authorization is required.		
J3385	Injection, velaglucerase alfa, 100 units	Prior authorization is required.		
13396				
	Injection, verteporfin, 0.1 mg	Prior authorization is required.		
J3397	Injection, vestronidase alfa-vjbk, 1 mg	Prior authorization is required.		
J3398	Injection, voretigene neparvovec-rzyl, 1 billion vector genomes	Prior authorization is required.		
J3489	Injection, zoledronic acid, 1 mg	Prior authorization is required.		
J3490	Unclassified drugs	The following drugs require prior authorization: Tegsedi, Nulibry, Uptravi		
J3590	Unclassified biologics	The following drugs require prior authorization: Hemgenix, Skysona, Zynteglo		
J7170	Injection, emicizumab-kxwh, 0.5 mg	Prior authorization is required.		
	Injection, von willebrand factor	The definition of the area.		
J7179	(recombinant), (vonvendi), 1 i.u. vwf:rco	Prior authorization is required.		
J7183	Injection, von willebrand factor complex (human), wilate, 1 i.u. vwf:rco	Prior authorization is required.		
J7185	Injection, factor viii (antihemophilic factor, recombinant) (xyntha), per i.u.	Prior authorization is required.		
J7186	Injection, antihemophilic factor viii/von willebrand factor complex (human), per factor viii i.u.	Prior authorization is required.		
J7187	Injection, von willebrand factor complex (humate-p), per iu vwf:rco	Prior authorization is required.		
	Factor viia (antihemophilic factor,			
J7189	recombinant), per 1 microgram	Prior authorization is required.	HHO-DE-MP-1088 Electroencephalogram (EEG) Technologies	
J7192	Factor viii (antihemophilic factor, recombinant) per i.u., not otherwise specified	Prior authorization is required.		
J7205	Injection, factor viii fc fusion protein (recombinant), per iu	Prior authorization is required.		
J7320	Hyaluronan or derivitive, genvisc 850, for	Prior authorization is required.		
17224	intra-articular injection, 1 mg			
J7321	Hyaluronan or derivative, hyalgan or supartz, for intra-articular injection, per dose	Prior authorization is required.		
J7323	Hyaluronan or derivative, euflexxa, for intra-	Prior authorization is required.		
	articular injection, per dose			
J7324	Hyaluronan or derivative, orthovisc, for intra- articular injection, per dose	Prior authorization is required.		
J7325	Hyaluronan or derivative, synvisc or synvisc- one, for intra-articular injection, 1 mg	Prior authorization is required.		
J7326	Hyaluronan or derivative, gel-one, for intra- articular injection, per dose	Prior authorization is required.		
J7327	Hyaluronan or derivative, monovisc, for intra- articular injection, per dose	Prior authorization is required.		
+	Hyaluronan or derivative, gelsyn-3, for intra-			
J7328	articular injection, 0.1 mg	Prior authorization is required.		
J7351	Injection, bimatoprost, intracameral implant, 1 microgram	Prior authorization is required.		
17644	Albuterol, inhalation solution, FDA-approved final product, noncompounded, administered	Need Under 18 no auth required;		
J7611	through DME, concentrated form, 1 mg	Prior authorization is required over 18		
+	Albuterol, inhalation solution, FDA-approved final product, noncompounded, administered	Need Under 18 no auth required;		
J7613	through DME, unit dose, 1 mg	Prior authorization is required over 18		
├ ──── ├				
J7686	Treprostinil, inhalation solution, fda-approved final product, non-compounded, administered through dme, unit dose form,	Prior authorization is required.		
J7799	1.74 mg NOC drugs, other than inhalation drugs, administered through DME	The following drugs and corresponding NDC codes require prior authorization: Empaveli		
		(73606001001)		
J9029	Injection, nadofaragene firadenovec-vncg, per therapeutic dose	Prior authorization is required.		
J9035	Injection, bevacizumab, 10 mg	Prior authorization is required.		
J9210	Injection, emapalumab-Izsg, 1 mg	Prior authorization is required.		
J9217	Leuprolide acetate (for depot suspension), 7.5	Prior authorization is required.		
J9312	Injection, rituximab, 10 mg	Prior authorization is required.		
	Injection, trastuzumab, excludes biosimilar, 10			
J9355	mg	Prior authorization is required.		
K0001	STANDARD WHEELCHAIR	Prior authorization is required when the billed charges are greater than \$500.		
K0002	STANDARD HEMI WHEELCHAIR	Prior authorization is required when the billed charges are greater than \$500.		
K0003	LIGHTWEIGHT WHEELCHAIR	Prior authorization is required when the billed charges are greater than \$500.		
K0004	HIGH STRENGTH LIGHTWEIGHT WHICHAIR	Prior authorization is required when the billed charges are greater than \$500.		
K0004		Prior authorization is required when the billed charges are greater than \$500.		
	LILTRALIGHTWEIGHT WHEELCHAIP			
KODOG	ULTRALIGHTWEIGHT WHEELCHAIR			
K0006	HEAVY-DUTY WHEELCHAIR	Prior authorization is required when the billed charges are greater than \$500.		
К0007	HEAVY-DUTY WHEELCHAIR EXTRA HEAVY-DUTY WHEELCHAIR	Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500.		
	HEAVY-DUTY WHEELCHAIR	Prior authorization is required when the billed charges are greater than \$500.		

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K0010	STD-WT FRME MOTRIZED/PWR WHLCHAIR	Prior authorization is required when the billed charges are greater than \$500.		
K0011	STD FRME MOTRIZD WHLCHAIR W/PROG	Prior authorization is required when the billed charges are greater than \$500.		
K0012	LGHTWT PRTBLE MOTRIZED/PWR WHLCHAIR	Prior authorization is required when the billed charges are greater than \$500.		
K0013	CUSTOM MOTORIZED/POWER WHEELCHAIR B	Prior authorization is required when the billed charges are greater than \$500.		
K0014	OTH MOTORIZED/POWER WHEELCHAIR BASE	Prior authorization is required when the billed charges are greater than \$500.		
K0015	DETACHBLE NONADJUSTBL HT ARMREST EA	Prior authorization is required when the billed charges are greater than \$500.		
K0017	DTACHBLE ADJUST HT ARMREST REPL EA	Prior authorization is required when the billed charges are greater than \$500.		
K0018	DTACH ADJ HT ARMRST UP PRTN REPL EA	Prior authorization is required when the billed charges are greater than \$500.		
K0019	ARM PAD REPLACEMENT ONLY EACH	Prior authorization is required when the billed charges are greater than \$500.		
K0020	FIXED ADJUSTBLE HEIGHT ARMREST PAIR	Prior authorization is required when the billed charges are greater than \$500.		
K0037	HIGH MOUNT FLIP-UP FOOTREST EACH	Prior authorization is required when the billed charges are greater than \$500.		
K0038	LEG STRAP EACH	Prior authorization is required when the billed charges are greater than \$500.		
K0039	LEG STRAP H STYLE EACH	Prior authorization is required when the billed charges are greater than \$500.		
K0040 K0041	ADJUSTABLE ANGLE FOOTPLATE EACH LARGE SIZE FOOTPLATE EACH	Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500.		
K0041	STANDARD SIZE FOOTPLATE EACH	Prior authorization is required when the billed charges are greater than \$500.		
K0042	FOOTREST LWR EXT TUBE REPLONLY EA	Prior authorization is required when the billed charges are greater than \$500.		
K0043	FOOTREST LWK EXT TOBE REPLONLY EA	Prior authorization is required when the billed charges are greater than \$500.		
K0044	FOOTREST OPRINGR BART REFEORET EA	Prior authorization is required when the billed charges are greater than \$500.		
K0045	ELEVAT LEGRST L EXT TUBE RPL ONLY E	Prior authorization is required when the billed charges are greater than \$500.		
K0040	ELEVAL ELEGIST E EXT TODE IN ECONT E	Prior authorization is required when the billed charges are greater than \$500.		
K0047	RATCHET ASSEMBLY REPLACEMENT ONLY	Prior authorization is required when the billed charges are greater than \$500.		
K0050	CAM RLS ASSM FTRST/LGRST RPL ONLY E	Prior authorization is required when the billed charges are greater than \$500.		
K0051	SWNGAWAY DTACHBLE FTRSTS RPL ONLY E	Prior authorization is required when the billed charges are greater than \$500.		
K0052	ELEVATING FOOTRESTS ARTICULATING EA	Prior authorization is required when the billed charges are greater than \$500.		
K0056	SEAT HT<17/=>21 IN LTWT/ULTRLT WC	Prior authorization is required when the billed charges are greater than \$500.		
K0065	SPOKE PROTECTORS EACH	Prior authorization is required when the billed charges are greater than \$500.		
K0069	RW ASM CMPL SOLID T SPKE/MLD RPL EA	Prior authorization is required when the billed charges are greater than \$500.		
K0070	RW ASM CMP PN T SPKS/MLD RPL ONLY E	Prior authorization is required when the billed charges are greater than \$500.		
K0071	FRT C ASM COMPL PN TIRE REPLONLY E	Prior authorization is required when the billed charges are greater than \$500.		
K0072	FRT C ASM CMPL SEMIPN T RPL ONLY E	Prior authorization is required when the billed charges are greater than \$500.		
K0073	CASTER PIN LOCK EACH	Prior authorization is required when the billed charges are greater than \$500.		
K0077	FRT C ASM CMPL SLD TIRE REPL ONLY E	Prior authorization is required when the billed charges are greater than \$500.		
K0098	DRIVE BELT FOR POWER WC REPL ONLY	Prior authorization is required when the billed charges are greater than \$500.		
K0105	IV HANGER EACH	Prior authorization is required when the billed charges are greater than \$500.		
K0108	Wheelchair component or accessory, not otherwise specified	Prior authorization is required for billed charges greater than \$500.		
K0195	ELEVATING LEGREST PAIR	Prior authorization is required when the billed charges are greater than \$500.		
K0455	INFUS PUMP UNINTRPT PARNTRAL MED	Prior authorization is required when the billed charges are greater than \$500.		
K0462	TEMP REPL PT EQUIP REPR ANY TYPE	Prior authorization is required when the billed charges are greater than \$500.		
K0552	Supplies for external noninsulin drug infusion pump, syringe type cartridge, sterile, each	Prior authorization is required for billed charges greater than \$500. Reference policies for	HHO-DE-MP-1134 Portable External Infusion Pump	
1/0552		additional information.		
K0553	SPLALLOW TX CGM1 MO SPL = 1 U SRVC	Prior authorization is required when the billed charges are greater than \$500.		
K0554	RECEIVER DEDICATED TX GCM SYS	Prior authorization is required when the billed charges are greater than \$500.		
K0601	Replacement battery for external infusion pump owned by patient, silver oxide, 1.5 volt,	Prior authorization is required for billed charges greater than \$500. Reference policies for additional information.	HHO-DE-MP-1134 Portable External Infusion Pump	
┝─────┼	each	Prior authorization is required for billed charges greater than \$500. Reference policies for		
K0602 F	Replacement battery for external infusion pump owned by patient, silver oxide, 3 volt, each	additional information.	HHO-DE-MP-1134 Portable External Infusion Pump	
		Prior authorization is required for billed charges greater than \$500. Reference policies for		
K0603	Replacement battery for external infusion pump owned by patient, alkaline, 1.5 volt, each	additional information.	HHO-DE-MP-1134 Portable External Infusion Pump	
KOCOL	Dealers and he have for a second s	Prior authorization is required for billed charges greater than \$500. Reference policies for		
K0604	Replacement battery for external infusion pump owned by patient, lithium, 3.6 volt, each	additional information.	HHO-DE-MP-1134 Portable External Infusion Pump	
K0605	Poplacement batteny for external infusion nume exceed by actions lithium of Functional	Prior authorization is required for billed charges greater than \$500. Reference policies for	HHO-DE-MP-1134 Portable External Infusion Pump	
KU0U5	Replacement battery for external infusion pump owned by patient, lithium, 4.5 volt, each	additional information.	HID-DE-IVIP-1134 PORTABLE EXTERNAL INTUSION PUMP	
K0606	A standation outproved and the illustrate with interpreted a last second in providence and taken as the second	Prior authorization is required for billed charges greater than \$500. Reference policies for	HHO-DE-MP-1138 Wearable Cardioverter-Defibrillator	
			THIS DE WE TISS Weatable Caldioverter-Delibiliator	
K0607	Automatic external defibrillator, with integrated electrocardiogram analysis, garment type	additional information.		
K0608	REPL BATTERY AUTO EXT DEFIB EA	Prior authorization is required when the billed charges are greater than \$500.		
	REPL BATTERY AUTO EXT DEFIB EA REPL GARMNT W/AUTO EXT DEFIB EA	Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500.		
K0609	REPL BATTERY AUTO EXT DEFIB EA REPL GARMNT W/AUTO EXT DEFIB EA REPL ELECTRODE W/AUTO EXT DEFIB EA	Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500.		
K0609 K0669	REPL BATTERY AUTO EXT DEFIB EA REPL GARMNT W/AUTO EXT DEFIB EA REPL ELECTRODE W/AUTO EXT DEFIB EA WC ACCSS SEAT/BK CUSHN NO DME PDAC	Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500.		
K0609 K0669 K0672	REPL BATTERY AUTO EXT DEFIB EA REPL GARMNT W/AUTO EXT DEFIB EA REPL ELECTRODE W/AUTO EXT DEFIB EA WC ACCES SEAT/BK CUSHIN NO DME PDAC ADD LOW EXT ORTHOSIS REPL EACH	Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500.		
K0609 K0669 K0672 K0730	REPL BATTERY AUTO EXT DEFIB EA REPL GARMNT W/AUTO EXT DEFIB EA REPL ELECTRODE W/AUTO EXT DEFIB EA WC ACCSS SEAT/BK CUSHN NO DME PDAC ADD LOW EXT ORTHOSIS REPL EACH CNTRL DOSE INTAL RX DEL ERY SYS	Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500.		
K0609 K0669 K0672	REPL BATTERY AUTO EXT DEFIB EA REPL GARMNT W/AUTO EXT DEFIB EA REPL ELECTRODE W/AUTO EXT DEFIB EA WC ACCES SEAT/BK CUSHIN NO DME PDAC ADD LOW EXT ORTHOSIS REPL EACH	Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500.		
K0609 K0669 K0672 K0730	REPL BATTERY AUTO EXT DEFIB EA REPL GARMNT W/AUTO EXT DEFIB EA REPL ELECTRODE W/AUTO EXT DEFIB EA WC ACCSS SEAT/BK CUSHN NO DME PDAC ADD LOW EXT ORTHOSIS REPL EACH CNTRL DOSE INTAL RX DEL ERY SYS	Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required for billed charges greater than \$500. Prior authorization is required for billed charges greater than \$500. Prior authorization is required for billed charges greater than \$500.	HHO-DE-MP-1072 Oxygen and HHO-DE-MP-1030 Home	
K0609 K0669 K0672 K0730 K0733 K0738	REPL BATTERY AUTO EXT DEFIB EA REPL GARMNT W/AUTO EXT DEFIB EA REPL ELECTRODE W/AUTO EXT DEFIB EA WC ACCSS SEAT/BK CUSHN NO DME PDAC ADD LOW EXT ORTHOSIS REPL EACH CNTRL DOSE INHAL RX DEL ERY SYS PWR WC 12-24 AMP HR LEAD BATT EACH PORT GASEOUS 02 SYS RNTL;HOM COMPRS	Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required to billed charges greater than \$500. Prior authorization is required for billed charges greater than \$500. Reference policies for additional information.	HHO-DE-MP-1072 Oxygen and HHO-DE-MP-1030 Home Oxygen Therapy	
K0609 K0669 K072 K0730 K0733 K0733 K0738 K0739	REPL BATTERY AUTO EXT DEFIB EA REPL GARMNT W/AUTO EXT DEFIB EA REPL ELECTRODE W/AUTO EXT DEFIB EA WC ACCSS SEAT/BK CUSHN NO DME PDAC ADD LOW EXT ORTHOSIS REPL EACH CNTRL DOSE INHAL RX DEL ERY SYS PWR WC 12-24 AMP HR LEAD BATT EACH PORT GASEOUS O2 SYS RNTL;HOM COMPRS REPR/SRVC DME NOT O2 PER 15 MINS	Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required the charges greater than \$500. Prior authorization is required the charges greater than \$500. Prior authorization is required then the billed charges are greater than \$500. Prior authorization is required then the billed charges are greater than \$500. Prior authorization is required then the billed charges are greater than \$500. Prior authorization is required then the billed charges are greater than \$500.		
K0609 K0669 K0730 K0733 K0738 K0739 K0740	REPL BATTERY AUTO EXT DEFIB EA REPL GARMNT W/AUTO EXT DEFIB EA REPL ELECTRODE W/AUTO EXT DEFIB EA WC ACCSS SEAT/BK CUSHN NO DME PDAC ADD LOW EXT ORTHOSIS REPL EACH CNTRL DOSE INHAL RX DEL ERY SYS PWR WC 12-24 AMP HR LEAD BATT EACH PORT GASEOUS O2 SYS RNTL;HOM COMPRS REPR/SRVC DME NOT O2 PER 15 MINS REPR/SRVC O2 EQP TECH PER 15 MINS	Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500.		
K0609 K0669 K0730 K0733 K0738 K0739 K0740 K0743	REPL BATTERY AUTO EXT DEFIB EA REPL GARMNT W/AUTO EXT DEFIB EA REPL ELECTRODE W/AUTO EXT DEFIB EA WC ACCSS SEAT/BK CUSHN NO DME PDAC ADD LOW EXT ORTHOSIS REPL EACH CNTRL DOSE INHAL RX DEL ERY SYS PWR WC 12-24 AMP HR LEAD BATT EACH PORT GASEOUS O2 SYS RNTL;HOM COMPRS REPR/SRVC DME NOT O2 PER 15 MINS REPR/SRVC 02 EQP TECH PER 15 MINS SX PUMP HOME MDL PORT FOR WOUNDS	Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500.		
K0609 K0669 K0672 K0730 K0733 K0738	REPL BATTERY AUTO EXT DEFIB EA REPL GARMNT W/AUTO EXT DEFIB EA REPL ELECTRODE W/AUTO EXT DEFIB EA WC ACCSS SEAT/BK CUSHN NO DME PDAC ADD LOW EXT ORTHOSIS REPL EACH CNTRL DOSE INHAL RX DEL ERY SYS PWR WC 12-24 AMP HR LEAD BATT EACH PORT GASEOUS 02 SYS RNTL;HOM COMPRS	Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required to billed charges greater than \$500. Prior authorization is required for billed charges greater than \$500. Reference policies for additional information.		
K0609 K0669 K0730 K0733 K0738 K0739 K0740	REPL BATTERY AUTO EXT DEFIB EA REPL GARMNT W/AUTO EXT DEFIB EA REPL ELECTRODE W/AUTO EXT DEFIB EA WC ACCSS SEAT/BK CUSHN NO DME PDAC ADD LOW EXT ORTHOSIS REPL EACH CNTRL DOSE INHAL RX DEL ERY SYS PWR WC 12-24 AMP HR LEAD BATT EACH PORT GASEOUS O2 SYS RNTL;HOM COMPRS REPR/SRVC DME NOT O2 PER 15 MINS REPR/SRVC O2 EQP TECH PER 15 MINS	Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500.		
K0609 K0669 K0730 K0733 K0738 K0739 K0740	REPL BATTERY AUTO EXT DEFIB EA REPL GARMNT W/AUTO EXT DEFIB EA REPL ELECTRODE W/AUTO EXT DEFIB EA WC ACCSS SEAT/BK CUSHN NO DME PDAC ADD LOW EXT ORTHOSIS REPL EACH CNTRL DOSE INHAL RX DEL ERY SYS PWR WC 12-24 AMP HR LEAD BATT EACH PORT GASEOUS O2 SYS RNTL;HOM COMPRS REPR/SRVC DME NOT O2 PER 15 MINS REPR/SRVC O2 EQP TECH PER 15 MINS	Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500.		

K0746	ABSRB WD DR H MDL PAD SZ >48 SQ IN	Prior authorization is required when the billed charges are greater than \$500.	
к0800	PWR OP VEH GRP 1 STD PT TO 300 LBS	Prior authorization is required when the billed charges are greater than \$500.	
K0801	PWR OP VEH GRP 1 HVY PT 301-450 LBS	Prior authorization is required when the billed charges are greater than \$500.	
K0802	PWR OP VEH GRP 1 HVY PT 451-600 LBS	Prior authorization is required when the billed charges are greater than \$500.	
K0806	PWR OP VEH GRP 2 STD PT TO 300 LBS	Prior authorization is required when the billed charges are greater than \$500.	
K0807	PWR OP VEH GRP 2 HVY PT 301-450 LBS	Prior authorization is required when the billed charges are greater than \$500.	
K0808	PWR OP VEH GRP 2 PT 451-600 LBS	Prior authorization is required when the billed charges are greater than \$500.	
K0812	Power operated vehicle, not otherwise classified	Prior authorization is required for billed charges greater than \$500.	
K0813	PWR WC GRP 1 SLING SEAT PT TO 300	Prior authorization is required when the billed charges are greater than \$500.	
K0814	PWR WC GRP 1 CAPT CHAIR PT TO 300	Prior authorization is required when the billed charges are greater than \$500.	
K0815	PWR WC GRP 1 SLING PT UP TO 300	Prior authorization is required when the billed charges are greater than \$500.	
K0815	PWR WC GRP 1 CAPT CHAIR PT TO 300	Prior authorization is required when the billed charges are greater than \$500.	
K0810	PWR WC GRP 2 SLING SEAT PT TO 300	Prior authorization is required when the billed charges are greater than \$500.	
K0820	PWR WC GRP 2 SLING SEAT PT TO 300		
K0821 K0822		Prior authorization is required when the billed charges are greater than \$500.	
	PWR WC GRP 2 SLING SEAT PT TO 300	Prior authorization is required when the billed charges are greater than \$500.	
K0823	PWR WC GRP 2 CAPT CHAIR PT TO 300	Prior authorization is required when the billed charges are greater than \$500.	
K0824	PWR WC GRP 2 SLING SEAT PT 301-450	Prior authorization is required when the billed charges are greater than \$500.	
K0825	PWR WC GRP 2 CAPT CHAIR PT 301-450	Prior authorization is required when the billed charges are greater than \$500.	
K0826	PWR WC GRP 2 SLING SEAT PT 451-600	Prior authorization is required when the billed charges are greater than \$500.	
K0827	PWR WC GRP 2 CAPT CHAIR PT 451-600	Prior authorization is required when the billed charges are greater than \$500.	
K0828	PWR WC GRP 2 SLING SEAT PT 601/>	Prior authorization is required when the billed charges are greater than \$500.	
K0829	PWR WC GRP 2X HVY DUTY CHR PT 601/>	Prior authorization is required when the billed charges are greater than \$500.	
K0830	PWR WC 2 SEAT ELEV SLING PT TO 300	Prior authorization is required when the billed charges are greater than \$500.	
K0830	PWR WC2 SEAT ELEV SERVET TO 300	Prior authorization is required when the billed charges are greater than \$500.	
K0835	PWR WC 2 SEAT ELEV CAPT PT TO 300 PWR WC GRP 2 1 PWR SLING PT TO 300	Prior authorization is required when the billed charges are greater than \$500.	+
K0835	PWR WC GRP 2 1 PWR SLING PT TO 300 PWR WC 2 1 PWR CAPT CHAIR PT TO 300	Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500.	<u> </u>
K0837	PWR WC GRP 2 1 PWR SLING PT 301-450	Prior authorization is required when the billed charges are greater than \$500.	
K0838	PWR WC 2 1 PWR CAPT CHR PT 301-450	Prior authorization is required when the billed charges are greater than \$500.	
К0839	PWR WC 2 1 PWR SLNG SEAT PT 451-600	Prior authorization is required when the billed charges are greater than \$500.	
K0840	PWR WC GRP 2 1 PWR SLING PT 601/>	Prior authorization is required when the billed charges are greater than \$500.	
K0841	PWR WC GRP 2 MX PWR SLING PT TO 300	Prior authorization is required when the billed charges are greater than \$500.	
K0842	PWR WC 2 MX PWR CAPT CHR PT TO 300	Prior authorization is required when the billed charges are greater than \$500.	
K0843	PWR WC 2 MX PWR SLING PT 301-450	Prior authorization is required when the billed charges are greater than \$500.	
K0848	PWR WC GRP 3 SLING SEAT PT TO &=300	Prior authorization is required when the billed charges are greater than \$500.	
К0849	PWR WC GRP 3 CAPT CHAIR PT TO &=300	Prior authorization is required when the billed charges are greater than \$500.	
K0850	PWR WC GRP 3 SLING SEAT PT 301-450	Prior authorization is required when the billed charges are greater than \$500.	
K0851	PWR WC GRP 3 CAPT CHAIR PT 301-450	Prior authorization is required when the billed charges are greater than \$500.	
K0852	PWR WC GRP 3 SLING SEAT PT 451-600	Prior authorization is required when the billed charges are greater than \$500.	
K0852	PWR WC GRP 3 CAPT CHAIR PT 451-600	Prior authorization is required when the billed charges are greater than \$500.	
K0855	PWR WC GRP 3 SLING SEAT PT 601 LB/>	Prior authorization is required when the billed charges are greater than \$500.	
K0855	PWR WC GRP 3 CAPT CHAIR PT 601 LB/>		
		Prior authorization is required when the billed charges are greater than \$500.	
K0856	PWR WC 3 1 PWR SLING SEAT PT TO 300	Prior authorization is required when the billed charges are greater than \$500.	
K0857	PWR WC 3 1 PWR CAPT CHAIR PT TO 300	Prior authorization is required when the billed charges are greater than \$500.	
K0858	PWR WC 3 1 PWR SLNG SEAT PT 301-450	Prior authorization is required when the billed charges are greater than \$500.	
K0859	PWR WC 3 1 CAP CHAIR PT 301-450	Prior authorization is required when the billed charges are greater than \$500.	
K0860	PWR WC 3 1 PWR SLNG SEAT PT 451-600	Prior authorization is required when the billed charges are greater than \$500.	
K0861	PWR WC 3 MX PWR SLNG SEAT PT TO 300	Prior authorization is required when the billed charges are greater than \$500.	
K0862	PWR WC 3 MX PWR SLING PT 301-450	Prior authorization is required when the billed charges are greater than \$500.	
K0863	PWR WC 3 MX PWR SLING PT 451-600	Prior authorization is required when the billed charges are greater than \$500.	
K0864	PWR WC 3 MX PWR SLNG SEAT PT 601/>	Prior authorization is required when the billed charges are greater than \$500.	
K0868	PWR WC GRP 4 SLING SEAT PT TO &=300	Prior authorization is required when the billed charges are greater than \$500.	
K0869	PWR WC GRP 4 CAPT CHAIR PT TO &=300	Prior authorization is required when the billed charges are greater than \$500.	
K0870	PWR WC GRP 4 SLING SEAT PT 301-450	Prior authorization is required when the billed charges are greater than \$500.	
K0870	PWR WC GRP 4 SLING SEAT PT 451-600	Prior authorization is required when the billed charges are greater than \$500.	
K0871 K0877	PWR WC 4 1 PWR SLING SEAT PT 451-000	Prior authorization is required when the billed charges are greater than \$500.	
K0877	PWR WC 4 1 PWR SLING SEAT PT TO 300 PWR WC 4 1 PWR CAPT CHAIR PT TO 300	Prior authorization is required when the billed charges are greater than \$500.	+ + + + + + + + + + + + + + + + + + + +
K0878 K0879	PWR WC 4 1 PWR CAPT CHAIR PT 10 300 PWR WC 4 1 PWR SLNG SEAT PT 301-450	Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500.	
K0880	PWR WC 4 1 PWR SLNG SEAT PT 451-600	Prior authorization is required when the billed charges are greater than \$500.	
K0884	PWR WC 4 MX PWR SLNG SEAT PT TO 300	Prior authorization is required when the billed charges are greater than \$500.	
K0885	PWR WC 4 MX PWR CAP CHAIR PT TO 300	Prior authorization is required when the billed charges are greater than \$500.	
K0886	PWR WC 4 MX PWR SLING PT 301-450	Prior authorization is required when the billed charges are greater than \$500.	
K0890	PWR WC 5 PED 1 PWR SLING PT TO 125	Prior authorization is required when the billed charges are greater than \$500.	
K0891	PWR WC 5 PED MX PWR SLING PT TO 125	Prior authorization is required when the billed charges are greater than \$500.	
K0898	Power wheelchair, not otherwise classified	Prior authorization is required for billed charges greater than \$500.	
K0899	PWR MOBILTY DEVC NOT CODED DME PDAC	Prior authorization is required when the billed charges are greater than \$500.	
К0900	CUSTOMIZED DME OTH THAN WHEELCHAIR	Prior authorization is required when the billed charges are greater than \$500.	
	ELEC POSIT OBS SLEEP APNEA TX SENS	Prior authorization is required when the billed charges are greater than \$500.	
K1001			
K1001 K1004	LOW FREQ U/S DIA TX DVC HOME USE	Prior authorization is required when the billed charges are greater than \$500.	

К1034	PROV COVID-19 TST NP 1 TST CNT	Prior authorization is required when the billed charges are greater than \$500.	
L0112	CRANIL CERV ORTHOS CONGN TORTICOLLI	Prior authorization is required when the billed charges are greater than \$500.	
L0113	CRANIL CERV ORTHOS TORTICOLLI PRFB	Prior authorization is required when the billed charges are greater than \$500.	
L0120	CERVICAL FLEX NONADJUSTABLE PREFAB	Prior authorization is required when the billed charges are greater than \$500.	
L0130	CERV FLXBL THRMOPLSTC COLLR MOLD PT	Prior authorization is required when the billed charges are greater than \$500.	
L0140	CERVICAL SEMI-RIGID ADJUSTABLE	Prior authorization is required when the billed charges are greater than \$500.	
L0150	CERV SEMI-RIGD ADJUST MOLD CHIN CUP	Prior authorization is required when the billed charges are greater than \$500.	
L0160	CERV SEMI-RIGID OCCIP/MAND PREFAB	Prior authorization is required when the billed charges are greater than \$500.	
L0170	CERV COLLAR MOLDED PATIENT MODEL	Prior authorization is required when the billed charges are greater than \$500.	
L0172	CERV COLLAR SEMI-RIGID FOAM PREFAB	Prior authorization is required when the billed charges are greater than \$500.	
L0174	CERV COLLR SEMI-RGD THOR EXT PREFAB	Prior authorization is required when the billed charges are greater than \$500.	
L0180	CERV MX POST COLLR SUPPS ADJ	Prior authorization is required when the billed charges are greater than \$500.	
L0190	CERV MX POST COLLR ADJ CERV BARS	Prior authorization is required when the billed charges are greater than \$500.	
L0200	CERV COLLR ADJ CERV BARS&THOR EXT	Prior authorization is required when the billed charges are greater than \$500.	
L0220	THORACIC RIB BELT CUSTOM FABRICATED	Prior authorization is required when the billed charges are greater than \$500.	
L0450	TLSO FLEX TRUNK SUPP UP THOR PREFAB	Prior authorization is required when the billed charges are greater than \$500.	
L0452	TLSO FLEX TRUNK SUPP UP THOR CUSTOM	Prior authorization is required when the billed charges are greater than \$500.	
L0454	TLSO FLEX SC JUNC T-9 PRFAB CUSTOM	Prior authorization is required when the billed charges are greater than \$500.	
L0455	TLSO FLEX SC JUNC TO T-9 PREFAB	Prior authorization is required when the billed charges are greater than \$500.	
L0456	TLSO FLEX SC SCAP SPN PRFAB CUSTOM	Prior authorization is required when the billed charges are greater than \$500.	
L0457	TLSO FLX SC JUNC TRM INF SCAP SPINE	Prior authorization is required when the billed charges are greater than \$500.	
L0458	TLSO TRIPLANR 2 SHELL ANT-XIPHOID	Prior authorization is required when the billed charges are greater than \$500.	
L0460	TLSO TRIPLANR 2 SHELL ANT-STERNL	Prior authorization is required when the billed charges are greater than \$500.	
L0462	TLSO TRIPLANR 3 SHELL ANT-STERNL	Prior authorization is required when the billed charges are greater than \$500.	
L0464	TLSO TRIPLANR 4 SHELL ANT-STERNL	Prior authorization is required when the billed charges are greater than \$500.	
L0466	TLSO SAGITTAL CONTROL PREFAB CUSTOM	Prior authorization is required when the billed charges are greater than \$500.	
L0467	TLSO SAGITTAL CONTROL RIGD PREFAB	Prior authorization is required when the billed charges are greater than \$500.	
L0468	TLSO SAGITTAL-CORONAL PREFAB CUSTOM	Prior authorization is required when the billed charges are greater than \$500.	
L0469	TLSO SAGITTAL-CORONAL CONTRL PREFAB	Prior authorization is required when the billed charges are greater than \$500.	
L0470	TLSO TRIPLANAR FRME&APRON W/STRAP	Prior authorization is required when the billed charges are greater than \$500.	
L0472	TLSO TRIPLANAR HYPREXT RIGD FRME	Prior authorization is required when the billed charges are greater than \$500.	
L0480	TLSO TRIPLANR 1 PC NO INTERFCE CSTM	Prior authorization is required when the billed charges are greater than \$500.	
L0482	TLSO TRIPLANAR 1 PC W/INTERFCE CSTM	Prior authorization is required when the billed charges are greater than \$500.	
L0484	TLSO TRIPLANR 2 PC NO INTERFCE CSTM	Prior authorization is required when the billed charges are greater than \$500.	
L0486	TLSO TRIPLANAR 2 PC W/INTERFCE CSTM	Prior authorization is required when the billed charges are greater than \$500.	
L0488	TLSO TRIPLANR 1 PC W/INTERFCE PRFAB	Prior authorization is required when the billed charges are greater than \$500.	
L0490	TLSO SAGIT-CORONAL REINFORCE PRFAB	Prior authorization is required when the billed charges are greater than \$500.	
L0491	TLSO 2 RIGID PLASTIC SHELLS PREFAB	Prior authorization is required when the billed charges are greater than \$500.	
L0492	TLSO 3 RIGID PLASTIC SHELLS PREFAB	Prior authorization is required when the billed charges are greater than \$500.	
L0621	SACROILIAC ORTHOSIS FLEXIBLE PREFAB	Prior authorization is required when the billed charges are greater than \$500.	
L0622	SACROILIAC ORTHOSIS FLEXIBLE CUSTOM	Prior authorization is required when the billed charges are greater than \$500.	
L0623	SACROILIAC ORTHOSIS I EDIALE COTOM	Prior authorization is required when the billed charges are greater than \$500.	
L0624	SACROILIAC ORTHOSIS RIGID CUSTOM	Prior authorization is required when the billed charges are greater than \$500.	
L0625	LUMBAR ORTHOSIS FLEXIBLE PREFAB	Prior authorization is required when the billed charges are greater than \$500.	
L0625	LUMB ORTHOS RIGID POST PREFAB CUSTM	Prior authorization is required when the billed charges are greater than \$500.	
L0620	LUMB ORTHOS RIGD A&P PNL PRFAB COSTM	Prior authorization is required when the billed charges are greater than \$500.	
L0628	LSO FLEXIBLE PREFAB OFF THE SHELF	Prior authorization is required when the billed charges are greater than \$500.	
L0628	LSO FLEXIBLE PREFAB OFF THE SHELF	Prior authorization is required when the billed charges are greater than \$500.	
L0630	LSO SAGIT CONTROL RIGID POST PREFAB	Prior authorization is required when the billed charges are greater than \$500.	
L0630	LSO SAGIT CONTROL RIGID POST CUSTOM	Prior authorization is required when the billed charges are greater than \$500.	
L0631 L0632	LSO SAGIT CNTRL RIGID A&P CUSTOM	Prior authorization is required when the billed charges are greater than \$500.	
L0632	LSO SAGE COR COTRL RIGID AGP COSTON	Prior authorization is required when the billed charges are greater than \$500.	
L0633	LSO SAG-COR CNI RE RIGID POST PREFAB	Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500.	
L0635	LSO SAG-COR CNTRE LIGID POST COSTOM	Prior authorization is required when the billed charges are greater than \$500.	
L0635	LSO SAG-COR CNI RE LUMB FLEX PREFAB	Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500.	
	LSO SAG-COR CNTRL LUMB FLEX CUSTOM LSO SAG-COR CNTRL RIGID A&P PREFAB		
L0637		Prior authorization is required when the billed charges are greater than \$500.	
L0638	LSO SAG-COR CNTRL RIGID A&P CUSTOM	Prior authorization is required when the billed charges are greater than \$500.	
L0638 L0639	LSO SAG-COR CNTRL RIGID A&P CUSTOM LSO SAG-COR CNTRL RIGD SHELL PREFAB	Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500.	
L0638 L0639 L0640	LSO SAG-COR CNTRL RIGID A&P CUSTOM LSO SAG-COR CNTRL RIGD SHELL PREFAB LSO SAG-COR CNTRL RIGD SHELL CUSTOM	Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500.	
L0638 L0639 L0640 L0641	LSO SAG-COR CNTRL RIGID A&P CUSTOM LSO SAG-COR CNTRL RIGD SHELL PREFAB LSO SAG-COR CNTRL RIGD SHELL CUSTOM LUMB ORTHOS SAGIT CTRL RIGD PST PNL	Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500.	
L0638 L0639 L0640 L0641 L0642	LSO SAG-COR CNTRL RIGID A&P CUSTOM LSO SAG-COR CNTRL RIGD SHELL PREFAB LSO SAG-COR CNTRL RIGD SHELL CUSTOM LUMB ORTHOS SAGIT CTRL RIGD PST PNL LUMB ORTHOS SAGIT CTRL ANT POST PNL	Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500.	
L0638 L0639 L0640 L0641 L0642 L0643	LSO SAG-COR CNTRL RIGID A&P CUSTOM LSO SAG-COR CNTRL RIGD SHELL PREFAB LSO SAG-COR CNTRL RIGD SHELL CUSTOM LUMB ORTHOS SAGIT CTRL RIGD PST PNL LUMB ORTHOS SAGIT CTRL ANT POST PNL LSO SAGITTAL CNTRL RIGID POST PANEL	Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500.	
L0638 L0639 L0640 L0641 L0642 L0643 L0643	LSO SAG-COR CNTRL RIGID A&P CUSTOM LSO SAG-COR CNTRL RIGD SHELL PREFAB LSO SAG-COR CNTRL RIGD SHELL CUSTOM LUMB ORTHOS SAGIT CTRL RIGD PST PNL LUMB ORTHOS SAGIT CTRL ANT POST PNL LSO SAGITTAL CNTRL RIGID POST PANEL LSO SAGIT CNTRL RIGD ANT POST PANEL	Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500.	Image: Constraint of the second sec
L0638 L0639 L0640 L0641 L0642 L0643 L0648 L0649	LSO SAG-COR CNTRL RIGID A&P CUSTOM LSO SAG-COR CNTRL RIGD SHELL PREFAB LSO SAG-COR CNTRL RIGD SHELL CUSTOM LUMB ORTHOS SAGIT CTRL RIGD PST PNL LUMB ORTHOS SAGIT CTRL ANT POST PNL LSO SAGITTAL CNTRL RIGID POST PANEL LSO SAGIT CNTRL RIGD ANT POST PANEL LSO SAGIT CNTRL RIGD PST PANEL LSO SAGIT-CORNL CNTRL RIGD PST PANEL	Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500.	Image: Constraint of the second of
L0638 L0639 L0640 L0641 L0642 L0643 L0648 L0649 L0650	LSO SAG-COR CNTRL RIGI D & P CUSTOM LSO SAG-COR CNTRL RIGD SHELL PREFAB LSO SAG-COR CNTRL RIGD SHELL CUSTOM LUMB ORTHOS SAGIT CTRL RIGD PST FNL LUMB ORTHOS SAGIT CTRL ANT POST PNL LSO SAGITTAL CNTRL RIGID POST PANEL LSO SAGIT CORRL COTRL RIGD POST PANEL LSO SAGIT CORRL CNTRL RIGD PT PANL LSO SAGIT-CORN. CNTRL RIGD PT PANL	Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500.	Image: Constraint of the second of
L0638 L0639 L0640 L0641 L0642 L0643 L0643 L0649 L0650 L0650	LSO SAG-COR CNTRL RIGID A&P CUSTOM LSO SAG-COR CNTRL RIGD SHELL PREFAB LSO SAG-COR CNTRL RIGD SHELL CUSTOM LUMB ORTHOS SAGIT CTRL RIGD PST PNL LUMB ORTHOS SAGIT CTRL ANT POST PNL LSO SAGIT CNTRL RIGID POST PANEL LSO SAGIT-CORNL CNTRL RIGD PST PANL LSO SAGIT-CORNL CNTRL ANT PST PANL LSO SAGIT-CORNL CNTRL ANT PST PANL LSO SAGIT-CORNL CNTRL ANT PST PANL LSO SAGIT-CORNL CNTRL RIGD SHLL/PNL	Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500.	
L0638 L0639 L0640 L0641 L0642 L0643 L0648 L0649 L0650	LSO SAG-COR CNTRL RIGI D & P CUSTOM LSO SAG-COR CNTRL RIGD SHELL PREFAB LSO SAG-COR CNTRL RIGD SHELL CUSTOM LUMB ORTHOS SAGIT CTRL RIGD PST FNL LUMB ORTHOS SAGIT CTRL ANT POST PNL LSO SAGITTAL CNTRL RIGID POST PANEL LSO SAGIT CORRL COTRL RIGD POST PANEL LSO SAGIT CORRL CNTRL RIGD PT PANL LSO SAGIT-CORN. CNTRL RIGD PT PANL	Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500.	Image: Constraint of the sector of

L0810	HALO PROC CERV HALO IN JACKT VEST	Prior authorization is required when the billed charges are greater than \$500.	
L0820	HALO PROC CERV HALO-PLAST BDY JACKT	Prior authorization is required when the billed charges are greater than \$500.	
L0830	HALO PROC CERV HALO-MLWAKEE ORTHOS	Prior authorization is required when the billed charges are greater than \$500.	
L0859	RINGS&PINS	Prior authorization is required when the billed charges are greater than \$500.	
L0861	ADD HALO PROC REPLCMT LINER/INTERFC	Prior authorization is required when the billed charges are greater than \$500.	
L0970	TLSO CORSET FRONT	Prior authorization is required when the billed charges are greater than \$500.	
L0970	LSO CORSET FROM	Prior authorization is required when the billed charges are greater than \$500.	
L0972	TLSO FULL CORSET		
		Prior authorization is required when the billed charges are greater than \$500.	
L0976	LSO FULL CORSET	Prior authorization is required when the billed charges are greater than \$500.	
L0978	AXILLARY CRUTCH EXTENSION	Prior authorization is required when the billed charges are greater than \$500.	
L0980	PERONEAL STRAPS PREFAB PAIR	Prior authorization is required when the billed charges are greater than \$500.	
L0982	STOCKING SUPPORT GRIPS PREFAB SET 4	Prior authorization is required when the billed charges are greater than \$500.	
L0984	PROTECTIVE BODY SOCK PREFAB EACH	Prior authorization is required when the billed charges are greater than \$500.	
L0999	Addition to spinal orthosis, not otherwise specified	Prior authorization is required for billed charges greater than \$500.	
L1000	CTLSO INCL FURNISH INIT ORTHOS-M DL	Prior authorization is required when the billed charges are greater than \$500.	
L1001	CTLS IMMOBILIZER INFANT SZ PREFAB	Prior authorization is required when the billed charges are greater than \$500.	
L1005	TENSION BASED SCOLIOSIS ORTHOSIS	Prior authorization is required when the billed charges are greater than \$500.	
L1010	ADD CTLSO/SCOLIO ORTHOS AX SLING	Prior authorization is required when the billed charges are greater than \$500.	
L1010	ADD CTLSO/SCOLIO ORTHOS AX SUNG	Prior authorization is required when the billed charges are greater than \$500.	h
L1025	ADD CTLSO/SCOLIO ORTHOS FYINOS FAD	Prior authorization is required when the billed charges are greater than \$500.	h
L1030	ADD CTLSO/SCOLIO ORTHOS LUMB PAD	Prior authorization is required when the billed charges are greater than \$500.	
L1040	ADD CTLSO/SCOLIO ORTHO LUMB/RIB PAD	Prior authorization is required when the billed charges are greater than \$500.	<u> </u>
L1050	ADD CTLSO/SCOLIOS ORTHOS STERNL PAD	Prior authorization is required when the billed charges are greater than \$500.	
L1060	ADD CTLSO/SCOLIOS ORTHOS THOR PAD	Prior authorization is required when the billed charges are greater than \$500.	
L1070	ADD CTLSO/SCOLIO ORTHO TRPEZUS SLNG	Prior authorization is required when the billed charges are greater than \$500.	
L1080	ADD CTLSO/SCOLIOSIS ORTHOSIS OUTRIG	Prior authorization is required when the billed charges are greater than \$500.	
L1085	ADD CTLSO/SCOLIO OUTRIG BIL-VRT EXT	Prior authorization is required when the billed charges are greater than \$500.	
L1090	ADD CTLSO/SCOLIOS ORTHOS LUM B SLING	Prior authorization is required when the billed charges are greater than \$500.	
L1100	ADD CTLSO/SCOLIOS RING PLSTC/LEATHR	Prior authorization is required when the billed charges are greater than \$500.	<u> </u>
L1110	ADD CTLSO/SCOLIOS RING MOLD PT MDL	Prior authorization is required when the billed charges are greater than \$500.	
L1110	ADD CTLSO SCOLIO ORTHO COVR UPRT EA	Prior authorization is required when the billed charges are greater than \$500.	h
L1120	TLSO INCL FURNISH INIT ORTHOS ONLY	Prior authorization is required when the billed charges are greater than \$500.	
L1210	ADDITION TLSO LATERAL THORACIC EXT	Prior authorization is required when the billed charges are greater than \$500.	
L1220	ADDITION TLSO ANT THORACIC EXT	Prior authorization is required when the billed charges are greater than \$500.	
L1230	ADD TLSO MLWAKEE TYPE SUPERSTRCT	Prior authorization is required when the billed charges are greater than \$500.	
L1240	ADDITION TLSO LUMBAR DEROTATION PAD	Prior authorization is required when the billed charges are greater than \$500.	
L1250	ADDITION TO TLSO ANTERIOR ASIS PAD	Prior authorization is required when the billed charges are greater than \$500.	
L1260	ADD TLSO ANT THOR DEROTATION PAD	Prior authorization is required when the billed charges are greater than \$500.	
L1270	ADDITION TO TLSO ABDOMINAL PAD	Prior authorization is required when the billed charges are greater than \$500.	
L1280	ADDITION TO TLSO RIB GUSSET EACH	Prior authorization is required when the billed charges are greater than \$500.	
L1290	ADDITION TLSO LAT TROCHANTERIC PAD	Prior authorization is required when the billed charges are greater than \$500.	
L1300	OTH SCOLIOS PROC BDY JACKT MOLD PT	Prior authorization is required when the billed charges are greater than \$500.	
L1310	OTH SCOLIOS FIRECED FISCAL MOLEFT	Prior authorization is required when the billed charges are greater than \$500.	h
L1499	Spinal orthosis, not otherwise specified	Prior authorization is required for billed charges greater than \$500.	
L1600	HIP ORTHOS ABDUCT FLX FREJKA PREFAB	Prior authorization is required when the billed charges are greater than \$500.	
L1610	HIP ORTHOS ABDUCT CNTRL FLEX PREFAB	Prior authorization is required when the billed charges are greater than \$500.	<u>↓</u>
L1620	HIP ORTHOS ABDUCT FLEX PAVLIK PRFAB	Prior authorization is required when the billed charges are greater than \$500.	
L1630	HIP ORTHOSIS ABDUCT CONTRL/SEMI-FLX	Prior authorization is required when the billed charges are greater than \$500.	
L1640	HIP ORTHOSIS-PELV BAND/SPRDR BAR	Prior authorization is required when the billed charges are greater than \$500.	
L1650	HIP ORTHOSIS ABDUCT CNTRL-STATC ADJ	Prior authorization is required when the billed charges are greater than \$500.	
L1652	HIP ORTHOS BIL THI CUFF ADLT PRFAB	Prior authorization is required when the billed charges are greater than \$500.	
L1660	HIP ORTHOS ABDUCT CNTRL-STATC PLSTC	Prior authorization is required when the billed charges are greater than \$500.	
L1680	HIP ORTHOS DYN PELV CNTRL THI CSTM	Prior authorization is required when the billed charges are greater than \$500.	<u> </u>
	Hip orthosis, bilateral hip joints and thigh cuffs, adjustable flexion, extension, abduction		
L1681	control of hip joint, postoperative hip abduction type, prefabricated item that has been	Prior authorization is required when the billed charges are greater than \$500.	
21001	trimmed, bent, molded, assembled, or otherwise customized to fit a spec		
L1685	HIP ORTHOS POSTOP HIP ABDCT CSTM	Prior authorization is required when the billed charges are greater than \$500.	
L1686	HIP ORTHOS POSTOP HIP ABOCT PREAB	Prior authorization is required when the billed charges are greater than \$500.	
L1690	COMB BIL LUMBO-SAC HIP FEM ORTHOS	Prior authorization is required when the billed charges are greater than \$500.	+
L1700	LEGG PERTHES ORTHOSIS TORONTO CSTM	Prior authorization is required when the billed charges are greater than \$500.	<u> </u>
			<u> </u>
L1710	LEGG PERTHES ORTHOS NEWINGTON CSTM	Prior authorization is required when the billed charges are greater than \$500.	
L1720	LEGG PERTHES ORTHO TRILAT TACHDIJAN	Prior authorization is required when the billed charges are greater than \$500.	ļ
L1730	LEGG PERTHES ORTHOSIS SCOTTISH RITE	Prior authorization is required when the billed charges are greater than \$500.	
L1755	LEGG PERTHES ORTHOS PATTEN BOTTOM	Prior authorization is required when the billed charges are greater than \$500.	
L1810	KNEE ORTHOSIS ELASTIC JOINTS PREFAB	Prior authorization is required when the billed charges are greater than \$500.	
L1812	KNEE ORTHOSIS ELASTIC W/JNTS PREFAB	Prior authorization is required when the billed charges are greater than \$500.	
L1820	KO ELAST W/CONDYLR PADS&JNT PRFAB	Prior authorization is required when the billed charges are greater than \$500.	
L1830	KNEE ORTHOSIS IMMOBLIZER PREFAB	Prior authorization is required when the billed charges are greater than \$500.	<u>† </u>
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L1831KNEE ORTHS LOCK KNEE LMT PSTN ORTHTPrior authorization is required when the billed charges are greater than \$500.L1832KNEE ORTHOS IMMOBIZA ADJUST PREFABPrior authorization is required when the billed charges are greater than \$500.L1833KNEE ORTHOS IS ADJUST INT RIGS DUPPPrior authorization is required when the billed charges are greater than \$500.L1834KO W/O KNEE JOINT RIGID CUSTOM FABPrior authorization is required when the billed charges are greater than \$500.L1836KNEE ORTHOSIS RIGD W/O JOINT PREFABPrior authorization is required when the billed charges are greater than \$500.L1840KO DEORTHON MED-LAT ACL CSTM FABPrior authorization is required when the billed charges are greater than \$500.L1843KNEE ORTHOS 1 UPRT THI&CALF PREFABPrior authorization is required when the billed charges are greater than \$500.L1844KNEE ORTHOS DELUPRT THI&CALF PREFABPrior authorization is required when the billed charges are greater than \$500.L1845KNEE ORTHOS DBLUPRT THI&CALF PREFABPrior authorization is required when the billed charges are greater than \$500.L1846KNEE ORTHOS DBLUPRT THI&CALF PREFABPrior authorization is required when the billed charges are greater than \$500.L1847KNEE ORTHOS DBLUPRT AD JNT PREFABPrior authorization is required when the billed charges are greater than \$500.L1848KNEE ORTHOS DBLUPRT AD JNT PREFABPrior authorization is required when the billed charges are greater than \$500.L1845KNEE ORTHOS DBLUPRT AD JNT PREFABPrior authorization is required when the billed charges are greater than \$500.L1846KNEE ORTHOS DBLUPRT AD JNT	
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L1834KO W/O KNEE JOINT RIGID CUSTOM FABPrior authorization is required when the billed charges are greater than \$500.L1836KNEE ORTHOSIS RIGO W/O JOINT PREFABPrior authorization is required when the billed charges are greater than \$500.L1840KO DEROTATION MED-LAT ALC CSTM FABPrior authorization is required when the billed charges are greater than \$500.L1843KNEE ORTHOS 1 UPRT THI&CALF PREFABPrior authorization is required when the billed charges are greater than \$500.L1844KNEE ORTHOS DBL UPRT THI&CALF PREFABPrior authorization is required when the billed charges are greater than \$500.L1845KNEE ORTHOS DBL UPRT THI&CALF PREFABPrior authorization is required when the billed charges are greater than \$500.L1846KNEE ORTHOS DBL UPRT THI&CALF PREFABPrior authorization is required when the billed charges are greater than \$500.L1847KNEE ORTHOS DBL UPRT THIBCALF PREFABPrior authorization is required when the billed charges are greater than \$500.L1848KNEE ORTHOS DBL UPRT AIS SUPP PREFABPrior authorization is required when the billed charges are greater than \$500.L1848KNEE ORTHOS DBL UPRT AIR SUPP PREFABPrior authorization is required when the billed charges are greater than \$500.L1850KNEE ORTHOS SWEDISH TYPE PREFABPrior authorization is required when the billed charges are greater than \$500.L1850KNEE ORTHOS SUB UPRT THIGH & CALFPrior authorization is required when the billed charges are greater than \$500.L1851KNEE ORTHOS SNE UPRT THIGH & CALFPrior authorization is required when the billed charges are greater than \$500.L1852KNEE ORTHOS SUB UPR	
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L1970 AFO PLASTIC W/ANK JOINT CUSTOM FAB Prior authorization is required when the billed charges are greater than \$500.	
L1971 ANK FT ORTHOS PLSTC/OTH MATL PREFAB Prior authorization is required when the billed charges are greater than \$500.	
L1980 AFO 1 UPRT DORSIFLX SLID STIRUP FAB Prior authorization is required when the billed charges are greater than \$500.	
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L284U ADD LVE EXT ORTHOS TIBLEN SOCK FX/= Prior authorization is required when the billed charges are greater than \$500.				
	L2840	ADD LW EXT ORTHOS TIB LEN SOCK FX/=	Prior authorization is required when the billed charges are greater than \$500.	

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L2850	ADD LW EXT ORTHO FEM LEN SOCK FX/=	Prior authorization is required when the billed charges are greater than \$500.	
L2861	ADD LOW EXT JNT KNEE/ANK CSTM EA	Prior authorization is required when the billed charges are greater than \$500.	
L2999	Lower extremity orthoses, not otherwise specified	Prior authorization is required for billed charges greater than \$500.	
L3000	FT INSRT MOLD UCB TYPE BERKLY SHELL	Prior authorization is required when the billed charges are greater than \$500.	
L3001	FOOT INSRT REMV MOLD PT SPENCO EA	Prior authorization is required when the billed charges are greater than \$500.	
L3002	FT INSRT REMV MOLD PLASTAZOTE/= EA	Prior authorization is required when the billed charges are greater than \$500.	
L3003	FOOT INSRT REMV MOLD SILCON GELEA	Prior authorization is required when the billed charges are greater than \$500.	
L3010	FT INSRT MOLD LNGTUDNL ARCH SUPP EA	Prior authorization is required when the billed charges are greater than \$500.	
L3020	FT INSRT REM V MOLD LNGTUDNL SUPP EA	Prior authorization is required when the billed charges are greater than \$500.	
L3030	FOOT INSERT REMV FORMED PT FT EA	Prior authorization is required when the billed charges are greater than \$500.	
L3031	FOOT INSRT/PLAT REMV ADD LW EXT ORS	Prior authorization is required when the billed charges are greater than \$500.	
L3040	FOOT ARCH SUPP PREMOLD LNGTUDNL EA	Prior authorization is required when the billed charges are greater than \$500.	
L3050	FOOT ARCH SUPP REM V PREMOLD MT EA	Prior authorization is required when the billed charges are greater than \$500.	
L3060	FT ARCH SUPP PREMOLD LNGTUDNL/MT EA	Prior authorization is required when the billed charges are greater than \$500.	
L3070	FOOT ARCH SUPP NONREMV LNGTUDNL EA	Prior authorization is required when the billed charges are greater than \$500.	
L3080	FT ARCH SUPP NONREMV ENGIGIBLE EA	Prior authorization is required when the billed charges are greater than \$500.	
L3090	FT ARCH SUPP NONREWV AT ICH SHOE MIT	Prior authorization is required when the billed charges are greater than \$500.	
L3100	HALLUS-VALGUS NIGHT DYN SPLNT PRFAB	Prior authorization is required when the billed charges are greater than \$500.	
L3140	FOOT ABDUCT ROTATION BAR INCL SHOES	Prior authorization is required when the billed charges are greater than \$500.	
L3150	FOOT ABDUCT ROTATION BAR W/O SHOES	Prior authorization is required when the billed charges are greater than \$500.	
L3160	FOOT ADJUSTBL SHOE-STYLD PSTN DEVC	Prior authorization is required when the billed charges are greater than \$500.	
L3161	Foot, adductus positioning device, adjustable	Prior authorization is required when the billed charges are greater than \$500.	
L3170	FOOT PLASTC SIL HEEL STAB PREFAB EA	Prior authorization is required when the billed charges are greater than \$500.	
L3201	ORTHOPED SHOE OXFRD SUPINATR INFNT	Prior authorization is required when the billed charges are greater than \$500.	
L3202	ORTHOPED SHOE OXFRD W/SUPINATR CHLD	Prior authorization is required when the billed charges are greater than \$500.	
L3203	ORTHOPED SHOE OXFRD W/SUPINATR JR	Prior authorization is required when the billed charges are greater than \$500.	
L3204	ORTHOPED SHOE HITOP SUPINATR INFNT	Prior authorization is required when the billed charges are greater than \$500.	
L3206	ORTHOPED SHOE HITOP W/SUPINATR CHLD	Prior authorization is required when the billed charges are greater than \$500.	
L3207	ORTHOPED SHOE HITOP W/SUPINATR JR	Prior authorization is required when the billed charges are greater than \$500.	
L3208	SURGICAL BOOT EACH INFANT	Prior authorization is required when the billed charges are greater than \$500.	
L3209	SURGICAL BOOT EACH CHILD	Prior authorization is required when the billed charges are greater than \$500.	
13211	SURGICAL BOOT EACH JUNIOR	Prior authorization is required when the billed charges are greater than \$500.	
L3212	BENESCH BOOT PAIR INFANT	Prior authorization is required when the billed charges are greater than \$500.	
L3212	BENESCH BOOT PAIR CHILD	Prior authorization is required when the billed charges are greater than \$500.	
L3213	BENESCH BOOT PAIR CHILD BENESCH BOOT PAIR UNIOR	Prior authorization is required when the billed charges are greater than \$500.	
L3214 L3215	ORTHOPED FTWEAR LADIES OXFORD EA	Prior authorization is required when the billed charges are greater than \$500.	
L3215 L3216	ORTHOFED FTWEAR LADIES SHOE DPTH INLAY	Prior authorization is required when the billed charges are greater than \$500.	
L3210 L3217	ORTHOPED FTWEAR LADIES SHOE DPTH INLAY	Prior authorization is required when the billed charges are greater than \$500.	
L3219	ORTHOPED FTWEAR MENS SHOE OXFORD EA		
L3221		Prior authorization is required when the billed charges are greater than \$500.	
L3222	ORTHOPD FTWEAR MENS SHOE DPTH INLAY	Prior authorization is required when the billed charges are greater than \$500.	
	ORTHO FTWEAR MENS HITOP DPTH INLAY	Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500.	
L3224	ORTHO FTWEAR MENS HITOP DPTH INLAY ORTHO FTWEAR WOMAN OXFRD PART BRACE	Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500.	
L3224 L3225	ORTHO FTWEAR MENS HITOP DPTH INLAY ORTHO FTWEAR WOMAN OXFRD PART BRACE ORTHO FTWEAR MAN OXFRD PART BRACE	Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500.	
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L3224 L3225 L3230 L3250	ORTHO FTWEAR MENS HITOP DPTH INLAY ORTHO FTWEAR WOMAN OXFRO PART BRACE ORTHO FTWEAR MAN OXFRO PART BRACE ORTHO FTWEAR CSTM SHOE DEPTH INLAY ORTHOPED FOOTWEAR CSTM MOLD PROSTH	Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500.	
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L3224 L3225 L3230 L3250 L3251 L3252 L3253 L3254 L3255	ORTHO FTWEAR MENS HITOP DPTH INLAY ORTHO FTWEAR WOMAN OXFRD PART BRACE ORTHO FTWEAR MAN OXFRD PART BRACE ORTHO FTWEAR CSTM SHOE DEPTH INLAY ORTHOPED FOOTWEAR CSTM MOLD PROSTH FOOT SHOE MOLD PT PLASTAZOTE CSTM FOOT SHOE MOLD PT PLASTAZOTE CSTM FOOT MOLD SHOE PLASTAZOTE CSTM FIT NONSTANDARD SIZE OR WIDTH NONSTANDARD SIZE OR LINGTH	Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500.	
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L3430			
	HEEL COUNTER PLASTIC REINFORCED	Prior authorization is required when the billed charges are greater than \$500.	
L3440	HEEL COUNTER LEATHER REINFORCED	Prior authorization is required when the billed charges are greater than \$500.	
L3450	HEEL SACH CUSHION TYPE	Prior authorization is required when the billed charges are greater than \$500.	
L3455	HEEL NEW LEATHER STANDARD	Prior authorization is required when the billed charges are greater than \$500.	
L3460	HEEL NEW RUBBER STANDARD	Prior authorization is required when the billed charges are greater than \$500.	
L3465	HEEL THOMAS WITH WEDGE	Prior authorization is required when the billed charges are greater than \$500.	
L3470	HEEL THOMAS EXTENDED TO BALL	Prior authorization is required when the billed charges are greater than \$500.	
L3480	HEEL PAD AND DEPRESSION FOR SPUR	Prior authorization is required when the billed charges are greater than \$500.	
L3485	HEEL PAD REMOVABLE FOR SPUR	Prior authorization is required when the billed charges are greater than \$500.	
L3500	ORTHOPED SHOE ADD INSOLE LEATHR	Prior authorization is required when the billed charges are greater than \$500.	
L3510	ORTHOPED SHOE ADD INSOLE RUBBER	Prior authorization is required when the billed charges are greater than \$500.	
L3520	ORTHO SHOE ADD INSOLE FELT W/LEATHR	Prior authorization is required when the billed charges are greater than \$500.	
L3530	ORTHOPEDIC SHOE ADDITION SOLE HALF	Prior authorization is required when the billed charges are greater than \$500.	
L3540	ORTHOPEDIC SHOE ADDITION SOLE FULL	Prior authorization is required when the billed charges are greater than \$500.	
L3550	ORTHOPED SHOE ADD TOE TAP STANDARD	Prior authorization is required when the billed charges are greater than \$500.	
L3560	ORTHOPED SHOE ADD TOE TAP HORSESHOE	Prior authorization is required when the billed charges are greater than \$500.	
L3570	ORTHOPED SHOE ADD SPCL EXT INSTEP	Prior authorization is required when the billed charges are greater than \$500.	
L3580	ORTHO SHOE ADD CNVRT INSTP-VELC CLO	Prior authorization is required when the billed charges are greater than \$500.	
L3590	ORTHO SHOE ADD CONVERT FIRM TO SOFT	Prior authorization is required when the billed charges are greater than \$500.	
L3595	ORTHOPEDIC SHOE ADDITION MARCH BAR		
L3595 L3600		Prior authorization is required when the billed charges are greater than \$500.	
	TRF ORTHOS 1 SHOE-ANR CALIP PL EXST	Prior authorization is required when the billed charges are greater than \$500.	
L3610	TX ORTHOS 1 SHOE-ANOTH CALIP PLT N	Prior authorization is required when the billed charges are greater than \$500.	
L3620	TRF ORTHOS 1 SHOE-ANOTH SLD STIR EX	Prior authorization is required when the billed charges are greater than \$500.	
L3630	TRNS ORTHOS 1 SHOE-ANOTH SLD STIR N	Prior authorization is required when the billed charges are greater than \$500.	
L3640	TRNS ORTHOS SHOE-SHOE DENNS BRWNE B	Prior authorization is required when the billed charges are greater than \$500.	
L3649	Orthopedic shoe, modification, addition or transfer, not otherwise specified	Prior authorization is required for billed charges greater than \$500.	
L3650	SHOULDER ORTHOS FIG 8 ABDUCT PREFAB	Prior authorization is required when the billed charges are greater than \$500.	
L3660	SHOULDER ORTHOS FIG 8 CANVAS PREFAB	Prior authorization is required when the billed charges are greater than \$500.	
L3670	SHOULDER ORTHOS ACROMIO/CLAV PREFAB	Prior authorization is required when the billed charges are greater than \$500.	
L3671	SO JOINT DESIGN W/O JOINTS CUSTOM	Prior authorization is required when the billed charges are greater than \$500.	
L3674	SHOULDER ORTHOSIS ABDUCT PSTN CSTM	Prior authorization is required when the billed charges are greater than \$500.	
L3675	SHLDR VEST ABDUCT RESTRAINR PREFAB	Prior authorization is required when the billed charges are greater than \$500.	
L3677	SHEDR VEST ABDUCT RESTRATING FREE AB		
		Prior authorization is required when the billed charges are greater than \$500.	
L3678	SHLDR ORTHOS JNT DSGN NO JNT PREFAB	Prior authorization is required when the billed charges are greater than \$500.	
L3702	EO W/O JOINTS CUSTOM FABRICATED	Prior authorization is required when the billed charges are greater than \$500.	
L3710	ELB ORTHOS ELASTIC METL JNTS PREFAB	Prior authorization is required when the billed charges are greater than \$500.	
L3720	EO DBL UPRT W/CUFF FREE MOT CSTM	Prior authorization is required when the billed charges are greater than \$500.	
L3730	EO DBL UPRT-CUFF EXT/FLX ASST CSTM	Prior authorization is required when the billed charges are greater than \$500.	
L3740	EO DBL UPRT W/CUFF ADJ LOCK CSTM	Prior authorization is required when the billed charges are greater than \$500.	
L3760			
	EO ADJ POS LOCKING JNT PREFAB ITEM	Prior authorization is required when the billed charges are greater than \$500.	
L3761	EO ADJ POS LOCKING JOINT PREFAB OTS	Prior authorization is required when the billed charges are greater than \$500.	
L3761 L3762	EO ADJ POS LOCKING JOINT PREFAB OTS ELBOW ORTHOS RIGID W/O JOINT PREFAB	Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500.	
L3761 L3762 L3763	EO ADJ POS LOCKING JOINT PREFAB OTS ELBOW ORTHOS RIGID W/O JOINT PREFAB EWHO RIGID W/O JOINTS CUSTOM FAB	Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500.	
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L3761 L3762 L3763 L3764 L3765	EO ADJ POS LOCKING JOINT PREFAB OTS ELBOW ORTHOS RIGID W/O JOINT PREFAB EWHO RIGID W/O JOINTS CUSTOM FAB EWHO 1/> NONTORSION INTS CSTM FAB EWHFO RIGID W/O JOINTS CUSTOM FAB	Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500.	Image: Constraint of the second sec
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L3761 L3762 L3763 L3764 L3765 L3766 L3806 L3807 L3808 L3809 L3809	EO ADJ POS LOCKING JOINT PREFAB OTS ELBOW ORTHOS RIGID W/O JOINT PREFAB EWHO RIGID W/O JOINTS CUSTOM FAB EWHO 1/> NONTORSION INTS CSTM FAB EWHFO RIGID W/O JOINTS CUSTOM FAB EWHFO 1/> NONTORSION INTS CSTM FAB WHFO 1/> NONTORSION INTS CSTM FAB WHFO CUSTOM FAB INCL FIT & ADJUST WHF ORTHOS NO INT PRFAB CUSTOM FIT WHF ORTHOSIS RIGID NO JNT; CUSTOM WHF ORTHON JOINTS PREFAB ANY TYPE ADD UP EXT JNT WRIST/FLELSCISTM EA	Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500.	Image: Constraint of the sector of
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L3761 L3762 L3763 L3764 L3765 L3766 L3806 L3807 L3808 L3809 L3891 L3900 L3901 L3904 L3904 L3905 L3906 L3908 L3913 L3915 L3915 L3916 L3917 L3918 L3919	EO ADJ POS LOCKING JOINT PREFAB OTS ELBOW ORTHOS RIGID W/O JOINT REFAB EWHO RIGID W/O JOINTS CUSTOM FAB EWHO 1/> NONTORSION INTS CSTM FAB EWHFO RIGID W/O JOINTS CUSTOM FAB EWHFO 1/> NONTORSION INTS CSTM FAB WHFO CUSTOM FAB INCL FIT & ADJUST WHF ORTHOS NO JNT PRFAB CUSTOM FIT WHF ORTHOS NO JNT PRFAB CUSTOM FIT WHF ORTHOS NO JNT PRFAB CUSTOM WHF ORTHON DJ JOINTS PREFAB ANT YPE ADD UP EXT JNT WRIST/ELB CSTM FAB WHFO DYN FLX HNG WRST DRVN CSTM FAB WHFO DYN FLX HNG WRST DRVN CSTM FAB WHFO DYN FLX HNG VABLE DRIVEN CSTM FAB WHFO DYN FLX HNG CABLE DRIVEN CSTM FAB WHFO DYN FLX HNG CABLE DRIVEN CSTM FAB WHO U/> JOINTS CSTAPS CSTM FAB WHO J/> NONTORSION JOINTS CSTM FAB HAND FINGS ORTHOS FIRAR CATED WH ORTHOS J/> NONTORSN PREFAS CSTM FIT HAND ORTHOS J/> NONTORSN JOINT PREFAB HAND ORTHOS J/> NONTORSN JOINT FREFAB CSTM FIT HAND ORTHOSISS METACARPL FX ORTHOSISS HAND ORTHOSISS METACARPL FX ORTHOSISS	Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the bille	Image: Constraint of the sector of
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L3761 L3762 L3763 L3764 L3765 L3766 L3806 L3807 L3808 L3809 L3891 L3900 L3901 L3904 L3904 L3905 L3906 L3906 L3906 L3912 L3913 L3915 L3916 L3917 L3918 L3919 L3921 L3923	EO ADJ POS LOCKING JOINT PREFAB OTS ELBOW ORTHOS RIGID W/O JOINT PREFAB EWHO RIGID W/O JOINTS CUSTOM FAB EWHFO I/> NONTORSION INTS CSTM FAB EWHFO I/> NONTORSION INTS CSTM FAB WHFO CISTOM FAB INCL FIT & ADJUST WHF ORTHOS NO JNT PRFAB CUSTOM FIT WHF ORTHON DO JOINTS PREFAB ANY TYPE ADD UP EXT JINT WINSTYCEL BCSTM EA WHFO DYN FLX HNG CABLE DRIVEN CSTM WHFO DYN FLX HNG CABLE DRIVEN CSTM FAB WHFO DYN FLX HNG CABLE DRIVEN CSTM FAB HO W/O JOINTS CUSTOM FABRICATED WH ORTHOS 1/> NONTORSN JOINT PREFAB HAND ORTHOSSIS MC FX PREFAB CSTM FIT HAND ORTHOSSIS MC DINT FX CUSTOM FAB HFO ONNOT ON DINTS CUSTOM FAB HFO ONNOT ON DINT FX CUSTOM FAB HFO ONNOT ON DINT FX CUSTOM FAB	Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the bille	Image: state s
L3761 L3762 L3763 L3764 L3765 L3766 L3806 L3807 L3808 L3809 L3891 L3900 L3901 L3904 L3904 L3905 L3906 L3906 L3908 L3912 L3915 L3915 L3915 L3917 L3918 L3919 L3919 L3919	EO ADJ POS LOCKING JOINT PREFAB OTS ELBOW ORTHOS RIGID W/O JOINT PREFAB EWHO RIGID W/O JOINTS CUSTOM FAB EWHO 1/> NONTORSION JNTS CSTM FAB EWHFO RIGID W/O JOINTS CUSTOM FAB EWHFO 1/> NONTORSION JNTS CSTM FAB WHFO CUSTOM FAB INCL FIT & ADJUST WHF ORTHOS NO JNT PRFAB CUSTOM FIT WHF ORTHOS NO JNT PRFAB CUSTOM FIT WHF ORTHOS NO JNT PRFAB CUSTOM FIT WHF ORTHOS NO JNT PRFAB CUSTOM STM WHFO RTHOS NO JNT PRFAB CUSTOM FIT WHF ORTHOS NO JNT PRFAB CUSTOM STM WHFO DYN FLX HING WRST DRWN CSTM FAB WHFO DYN FLX HING WRST DRWN CSTM FAB WHFO DYN FLX HING CABLE DRIVEN CSTM WHFO DYN FLX HING CABLE DRIVEN CSTM WHFO DYN FLX HING CABLE DRIVEN CSTM WHFO DYN FLX HING CABLE DRIVEN CSTM FAB WHO 1/> NONTORSION JOINTS CSTM FAB WHO J/> NONTORSION JOINTS CSTM FAB HAND FINGR ORTHOS FINGR CNTRL PRFAB HAND FINGS DY/> NONTORSN PRFAB CSTM FIT WH ORTHOS J/> NONTORSN DRFAB CSTM FIT WH ORTHOS SI MCTACARPL FX ORTHOSIS HAND ORTHOSIS MCTACARPL FX ORTHOSIS HAND ORTHOSIS W/O JOINTS CUSTOM FABB HFO J/> NONTORSION JOINTS CUSTOM FAB HFO J/> NONTORSION JOINTS CUSTOM FAB	Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the bille	Image: style s

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

L5280	HEMIPELVECT CANADIAN; MOLD SOCKT	Prior authorization is required when the billed charges are greater than \$500.	
L5301	BK MOLD SCKT SHIN SACH FT ENDO SYS	Prior authorization is required when the billed charges are greater than \$500.	
L5312	KNEE DISART MOLD SOCKET 1 AXIS KNEE	Prior authorization is required when the billed charges are greater than \$500.	
L5321	AK OPEN END SACH FT ENDO SYS 1 AXIS	Prior authorization is required when the billed charges are greater than \$500.	
L5331	JOINT SINGLE AXIS KNEE SACH FOOT	Prior authorization is required when the billed charges are greater than \$500.	
L5341	SINGLE AXIS KNEE SACH FOOT	Prior authorization is required when the billed charges are greater than \$500.	
L5400	IMMED POSTSURG RIGD DRSG W/1 CHG BK	Prior authorization is required when the billed charges are greater than \$500.	
L5410	IMMED POSTSURG RIGD DRS BK-EA CAST	Prior authorization is required when the billed charges are greater than \$500.	
L5420	IMMED POSTSURG RIGD DRSG 1 CHG AK	Prior authorization is required when the billed charges are greater than \$500.	
L5430	IMMED POSTSURG RIGD DRSG AK EA CAST	Prior authorization is required when the billed charges are greater than \$500.	
L5450	IMMED POSTSURG NOD DISG AK EA CAST	Prior authorization is required when the billed charges are greater than \$500.	
L5460			
	IMMED POSTSURG NONWT BEAR RIGD AK	Prior authorization is required when the billed charges are greater than \$500.	
L5500	INIT BK PTB SCKT NON-ALIGN DIR FORM	Prior authorization is required when the billed charges are greater than \$500.	
L5505	INIT AK-DISRTC ISCH LEVL NON-ALIGN	Prior authorization is required when the billed charges are greater than \$500.	
L5510	PREP BK PTB SCKT NON-ALIGN MOLD MDL	Prior authorization is required when the billed charges are greater than \$500.	
L5520	PREP BK PTB THERMOPLSTC/=DIR FORM	Prior authorization is required when the billed charges are greater than \$500.	
L5530	PREP BK PTB THERMOPLSTC/=MOLD MODEL	Prior authorization is required when the billed charges are greater than \$500.	
L5535	PREP BK PTB PRFAB ADJ OPEN END SCKT	Prior authorization is required when the billed charges are greater than \$500.	
L5540	PREP BK PTB LAMINATED SCKT MOLD MDL	Prior authorization is required when the billed charges are greater than \$500.	
L5560	PREP AK-DISARTIC PLASTER MOLD MODEL	Prior authorization is required when the billed charges are greater than \$500.	
L5570	PREP AK-DISRTC THRMOPLSTC/=DIR FORM	Prior authorization is required when the billed charges are greater than \$500.	
L5580	PREP AK-DISARTIC THERMOPLSTC/=MOLD	Prior authorization is required when the billed charges are greater than \$500.	
L5585	PREP AK-DISARTIC PRFAB ADJ OPEN END	Prior authorization is required when the billed charges are greater than \$500.	
L5590	PREP AK-DISARTC LAMINATD SCKT MOLD	Prior authorization is required when the billed charges are greater than \$500.	
L5595	PREP HIP DISARTC THERMOPLSTC/=MOLD	Prior authorization is required when the billed charges are greater than \$500.	
L5600	PREP HIP DISARTC LIMINATD SCKT MOLD	Prior authorization is required when the billed charges are greater than \$500.	+
L5610	ADD LOW EXTRM ENDO AK HYDRACADENCE	Prior authorization is required when the billed charges are greater than \$500.	
L5611	ADD LW EXT AK-DISARTC W/FRICT CNTRL	Prior authorization is required when the billed charges are greater than \$500.	
L5613	ADD LW EXT AK-DISAKTC W/FRICT CVTRL	Prior authorization is required when the billed charges are greater than \$500.	
L5614	ADD LW EXT AK-DSRTC W/PNEUMAT CNTRL	Prior authorization is required when the billed charges are greater than \$500.	
L5615	Addition, endoskeletal knee-shin system, 4 bar linkage or multiaxial, fluid swing and stance	Prior authorization is required when the billed charges are greater than \$500.	
15646	phase control		
L5616	ADD LOW EXT AK UNIVRSL MXPLX FRICT	Prior authorization is required when the billed charges are greater than \$500.	
L5617	ADD LW EXTREM QUICK CHANGE AK/BK EA	Prior authorization is required when the billed charges are greater than \$500.	
L5617 L5618	ADD LW EXTREM QUICK CHANGE AK/BK EA ADD LOW EXTREM TEST SOCKT SYMES	Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500.	
L5617 L5618 L5620	ADD LW EXTREM QUICK CHANGE AK/BK EA ADD LOW EXTREM TEST SOCKT SYMES ADD LOW EXTREM TEST SOCKT BELW KNEE	Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500.	
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L5666	ADD LOW EXTREM BELOW KNEE CUFF SUSP	Prior authorization is required when the billed charges are greater than \$500.	
L5668	ADD LW EXTRM BK MOLD DISTAL CUSHION	Prior authorization is required when the billed charges are greater than \$500.	
L5670	ADD LW EXTRM BK MOLD SUPRACOND SUSP	Prior authorization is required when the billed charges are greater than \$500.	
L5671	ADD LOW EXTRM BK/AK SUSP LOCK MECH	Prior authorization is required when the billed charges are greater than \$500.	
L5672	ADD LOW EXTRM BK REMV MED BRIM SUSP	Prior authorization is required when the billed charges are greater than \$500.	
L5673	ADD LOW EXT BK/AK CSTM FAB XST MOLD	Prior authorization is required when the billed charges are greater than \$500.	
L5676	ADD LOW EXT BK KNEE JNT 1 AXIS PAIR	Prior authorization is required when the billed charges are greater than \$500.	
L5677	ADD LW EXT BK KNEE JNT POLYCNTRC PR	Prior authorization is required when the billed charges are greater than \$500.	
L5678	ADD LW EXT BELW KNEE JNT COVRS PAIR	Prior authorization is required when the billed charges are greater than \$500.	
L5679	ADD LOW EXT BK/AK CSTM FAB XST MOLD	Prior authorization is required when the billed charges are greater than \$500.	
L5680	ADD LOW EXTRM BK THI LACER NONMOLD	Prior authorization is required when the billed charges are greater than \$500.	
L5681			
L5681	ADD LW EXT BK/AK CONGN/AMPUTEE INIT	Prior authorization is required when the billed charges are greater than \$500.	
	ADD LOW EXTREM BK THIGH LACER MOLD	Prior authorization is required when the billed charges are greater than \$500.	
L5683	ADD LOW EXT BK/AK NO CONGN/AMP INIT	Prior authorization is required when the billed charges are greater than \$500.	
L5684	ADD LOW EXTREM BELW KNEE FORK STRAP	Prior authorization is required when the billed charges are greater than \$500.	
L5685	ADD LOW EXT PROS BELW KNEE SLEEVE	Prior authorization is required when the billed charges are greater than \$500.	
L5686	ADD LOW EXTREM BELW KNEE BACK CHECK	Prior authorization is required when the billed charges are greater than \$500.	
L5688	ADD LOWER EXTRM BK WAIST BELT WEBNG	Prior authorization is required when the billed charges are greater than \$500.	
L5690	ADD LOW EXTRMITY BK WAIST BELT PAD	Prior authorization is required when the billed charges are greater than \$500.	
L5692	ADD LW EXTRM AK PELVIC CONTROL BELT	Prior authorization is required when the billed charges are greater than \$500.	
L5694	ADD LW EXTRM AK PELV CNTRL BELT PAD	Prior authorization is required when the billed charges are greater than \$500.	
L5695	ADD LW EXT AK PELV CNTRL SLV NEOPRN	Prior authorization is required when the billed charges are greater than \$500.	
L5696	ADD LOW EXTRM AK/DISARTIC PELV JNT	Prior authorization is required when the billed charges are greater than \$500.	<u> </u>
L5697	ADD LOW EXTRM AK/DISARTIC FELV SM	Prior authorization is required when the billed charges are greater than \$500.	
L5698	ADD LOW EXTRIM AK/KD SILESIAN BANDAGE	Prior authorization is required when the billed charges are greater than \$500.	ł – – – – – – – – – – – – – – – – – – –
L5698 L5699			
L5699 L5700	ALL LOW EXTREM PROSTH SHLDR HARNESS	Prior authorization is required when the billed charges are greater than \$500.	<u> </u>
	REPL SOCKET BELOW KNEE MOLD PT MDL	Prior authorization is required when the billed charges are greater than \$500.	
L5701	REPL SCKT AK/DISARTIC W/ ATTCH PLAT	Prior authorization is required when the billed charges are greater than \$500.	
L5702	REPLSCKT HIP DISRTC W/HIP JNT MOLD	Prior authorization is required when the billed charges are greater than \$500.	
L5703	ANK SYMES MLD PT MDL SACH FT REPL	Prior authorization is required when the billed charges are greater than \$500.	
L5704	CUSTOM SHAP PROTVE COVER BELOW KNEE	Prior authorization is required when the billed charges are greater than \$500.	
L5705	CUSTOM SHAP PROTVE COVER ABOVE KNEE	Prior authorization is required when the billed charges are greater than \$500.	
L5706	CUSTOM SHAPED COVER KNEE DISARTIC	Prior authorization is required when the billed charges are greater than \$500.	
L5707	CUSTOM SHAPED COVER HIP DISARTIC	Prior authorization is required when the billed charges are greater than \$500.	
L5710	ADD EXOSKL KNEE-SHIN 1 AXS MNL LOCK	Prior authorization is required when the billed charges are greater than \$500.	
L5711	ADD EXO KNEE-SHIN MNL LOCK ULTRA-LT	Prior authorization is required when the billed charges are greater than \$500.	
L5712	ADD EXO KNEE-SHIN FRICT SWING CNTRL	Prior authorization is required when the billed charges are greater than \$500.	
L5714	ADD EXO KNEE-SHIN VARBL FRICT SWING	Prior authorization is required when the billed charges are greater than \$500.	
L5716	ADD EXO KNEE-SHIN MECH STANCE LOCK	Prior authorization is required when the billed charges are greater than \$500.	
L5718	ADD EXO KNEE SHIN RECHTARE LOCK	Prior authorization is required when the billed charges are greater than \$500.	
L5722	ADD EXO KNEE-SHIN PRICE SWING CREAL		
L3/22			
15724		Prior authorization is required when the billed charges are greater than \$500.	
L5724	ADD KNEE-SHIN 1 AXIS FL SWING PHASE	Prior authorization is required when the billed charges are greater than \$500.	
L5726	ADD KNEE-SHIN 1 AXIS FL SWING PHASE ADD EXO KNEE-SHIN EXT JNT FL SWING	Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500.	
L5726 L5728	ADD KNEE-SHIN 1 AXIS FL SWING PHASE ADD EXO KNEE-SHIN EXT JNT FL SWING ADD EXO KNEE-SHIN FL SWING&STANCE	Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500.	
L5726 L5728 L5780	ADD KNEE-SHIN 1 AXIS FL SWING PHASE ADD EXO KNEE-SHIN EXT INT FL SWING ADD EXO KNEE-SHIN FL SWING&STANCE ADD EXO KNEE-SHIN PNEUMAT/HYDRA	Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500.	
L5726 L5728 L5780 L5781	ADD KNEE-SHIN 1 AXIS FL SWING PHASE ADD EXO KNEE-SHIN EXT JNT FL SWING ADD EXO KNEE-SHIN FL SWING&STANCE ADD EXO KNEE-SHIN PNEUMAT/HYDRA ADD LW LIMB PROS LIMB MGMT SYS	Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500.	Image: Constraint of the second sec
L5726 L5728 L5780 L5781 L5782	ADD KNEE-SHIN 1 AXIS FL SWING PHASE ADD EXO KNEE-SHIN EXT JNT FL SWING ADD EXO KNEE-SHIN FL SWING&STANCE ADD EXO KNEE-SHIN PNEUMAT/HYDRA ADD LW LIMB PROS LIMB MGMT SYS ADD LW LIMB PROS LIMB MGMT HVY DUTY	Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500.	
L5726 L5728 L5780 L5781 L5782 L5785	ADD KNEE-SHIN 1 AXIS FL SWING PHASE ADD EXO KNEE-SHIN EXT JNT FL SWING ADD EXO KNEE-SHIN FL SWING&STANCE ADD EXO KNEE-SHIN PNEUMAT/HYDRA ADD LW UIMB PROS LIMB MGMT SYS ADD LW UIMB PROS LIMB MGMT HVY DUTY ADD EXOSKEL BELW KNEE ULTRA-LT MATL	Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500.	
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L5858	ADD LW EXT PROS KNEE SHN SYS STANCE	Prior authorization is required when the billed charges are greater than \$500.		
L5859	ADD LW EXT PROS KN-SHN PROG FLX/EXT	Prior authorization is required when the billed charges are greater than \$500.		
L5910	ADD ENDOSKEL BELOW KNEE ALIGNBL SYS	Prior authorization is required when the billed charges are greater than \$500.		
L5920	ADD ENDOSKEL AK/HIP DISRTC ALIGNBL	Prior authorization is required when the billed charges are greater than \$500.		
L5925	ADD ENDO AK/HIP DISARTIC MINL LOCK	Prior authorization is required when the billed charges are greater than \$500.		
15026	Addition to lower extremity prosthesis, endoskeletal, knee disarticulation, above knee, hip			
L5926	disarticulation, positional rotation unit, any type	Prior authorization is required when the billed charges are greater than \$500.		
L5930	ADD ENDO HI ACTV KNEE CNTRL FRAME	Prior authorization is required when the billed charges are greater than \$500.		
L5940	ADD ENDOSKEL BELOW KNEE ULTRA-LGHT	Prior authorization is required when the billed charges are greater than \$500.		
L5950	ADD ENDOSKEL ABOVE KNEE ULTRA-LGHT	Prior authorization is required when the billed charges are greater than \$500.		
L5960	ADD ENDOSKL HIP DISARTC ULTRA-LGHT	Prior authorization is required when the billed charges are greater than \$500.		
L5961	ADD ENDO SYS POLYCNTRC HIP JOINT	Prior authorization is required when the billed charges are greater than \$500.		
L5961				
	ADD ENDO BK FLEX PROTVE OUTER COVER	Prior authorization is required when the billed charges are greater than \$500.		
L5964	ADD ENDO AK FLXBL PROTVE OUTR COVER	Prior authorization is required when the billed charges are greater than \$500.		
L5966	ADD ENDO HIP DISRTC FLX PROTVE COVR	Prior authorization is required when the billed charges are greater than \$500.		
L5968	ADD LW LIMB PROSTH MX-AXIAL ANKLE	Prior authorization is required when the billed charges are greater than \$500.		
L5969	ADD ENDOSKEL ANKL-FT/ANK PWR ASSIST	Prior authorization is required when the billed charges are greater than \$500.		
L5970	ALL LW EXTRM PROSTH FOOT SACH FOOT	Prior authorization is required when the billed charges are greater than \$500.		
L5971	ALL LW EXT PROS SACH FOOT REPLONLY	Prior authorization is required when the billed charges are greater than \$500.		
L5972	ALL LOW EXT PROS FOOT FLEXIBLE KEEL	Prior authorization is required when the billed charges are greater than \$500.		
L5973	ENDO ANK FOOT MICROPROCSS CNTRL PWR	Prior authorization is required when the billed charges are greater than \$500.		
L5974	ALL LW EXTRM PRSTH FT 1 AXIS ANK/FT	Prior authorization is required when the billed charges are greater than \$500.		
L5975	ALL LW EXTRM PROSTH COMB 1 AXIS ANK	Prior authorization is required when the billed charges are greater than \$500.		
L5976	ALL LW EXTRM PROSTH ENERGY STOR FT	Prior authorization is required when the billed charges are greater than \$500.		
L5978	ALL LW EXTRM PRSTH FT MX-AXL ANK/FT	Prior authorization is required when the billed charges are greater than \$500.		
L5979	ALL LW XTRM PRSTH MX-AXL ANK 1 PECE	Prior authorization is required when the billed charges are greater than \$500.		1
L5980	ALL LOW EXTREM PROSTH FLX-FOOT SYS	Prior authorization is required when the billed charges are greater than \$500.		
L5981	ALL LOW EXTREM PROSTIL FLX-WALK SYS/=			
		Prior authorization is required when the billed charges are greater than \$500.		
L5982	ALL EXOSKEL LW EXT PROS AXIAL ROTAT	Prior authorization is required when the billed charges are greater than \$500.		
L5984	ALL ENDOSKEL LW EXT PRSTH AXL ROTAT	Prior authorization is required when the billed charges are greater than \$500.		
L5985	ALL ENDOSKL LW XTRM PROSTH DYNAMIC	Prior authorization is required when the billed charges are greater than \$500.		
L5986	ALL LW EXTRM PROSTH MX-AXIAL ROT U	Prior authorization is required when the billed charges are greater than \$500.		
L5987	ALL LW EXTRM PROSTH SHANK FOOT SYS	Prior authorization is required when the billed charges are greater than \$500.		
L5988	ADD LW LMB PRSTH VERTCL SHOCK RDUC	Prior authorization is required when the billed charges are greater than \$500.		
L5990	ADD LW EXTRM PROSTH USE ADJ HEEL HT	Prior authorization is required when the billed charges are greater than \$500.		
L5990 L5991 L5999	ADD LW EXTRM PROSTH USE ADJ HEEL HT Addition to lower extremity prostheses, osseointegrated external prosthetic connector Lower extremity prosthesis, not otherwise specified	Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500.		
L5990 L5991	ADD LW EXTRM PROSTH USE ADJ HEEL HT Addition to lower extremity prostheses, osseointegrated external prosthetic connector	Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500.		
L5990 L5991 L5999	ADD LW EXTRM PROSTH USE ADJ HEEL HT Addition to lower extremity prostheses, osseointegrated external prosthetic connector Lower extremity prosthesis, not otherwise specified	Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500.		
L5990 L5991 L5999 L6000	ADD LW EXTRM PROSTH USE ADJ HEEL HT Addition to lower extremity prostheses, osseointegrated external prosthetic connector Lower extremity prosthesis, not otherwise specified PARTIAL HAND THUMB REMAINING	Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500.		
L5990 L5991 L5999 L6000 L6010 L6020	ADD LW EXTRM PROSTH USE ADJ HEEL HT Addition to lower extremity prostheses, osseointegrated external prosthetic connector Lower extremity prosthesis, not otherwise specified PARTIAL HAND THUMB REMAINING PARTIAL HAND DITUE &/ RING FINGER REM PARTIAL HAND NO FINGER REMAINING	Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500.		
L5990 L5991 L5999 L6000 L6010	ADD LW EXTRM PROSTH USE ADJ HEEL HT Addition to lower extremity prostheses, osseointegrated external prosthetic connector Lower extremity prosthesis, not otherwise specified PARTIAL HAND THUMB REMAINING PART HAND LITTLE &/ RING FINGER REM	Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500.	HHO-DE-MP-1031 Myolectric Upper Extremity Orthoses	
L5990 L5991 L5999 L6000 L6010 L6020	ADD LW EXTRM PROSTH USE ADJ HEEL HT Addition to lower extremity prostheses, osseointegrated external prosthetic connector Lower extremity prosthesis, not otherwise specified PARTIAL HAND THUMB REMAINING PARTIAL HAND DITUE &/ RING FINGER REM PARTIAL HAND NO FINGER REMAINING	Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges greater than \$500. Prior authorization is required the	HHO-DE-MP-1031 Myolectric Upper Extremity Orthoses	
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L6722	TERM DEVC HOOK/HND HD MECH VOL CLOS	Prior authorization is required when the billed charges are greater than \$500.		
L6805	ADD TERM DEVICE MODIFIER WRIST UNIT	Prior authorization is required when the billed charges are greater than \$500.		
L6810	ADD TERM DEVC PRECISION PINCH DEVC	Prior authorization is required when the billed charges are greater than \$500.		
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L6881	AUTO GRASP ADD UPPER LIMB PROS DEVC	Prior authorization is required when the billed charges are greater than \$500.		
L6882	MICRPROCSS CNTRL ADD UP LIMB PROSTH	Prior authorization is required when the billed charges are greater than \$500.		
L6883	REPL SOCKET BE/WD MOLDED TO PT MDL	Prior authorization is required when the billed charges are greater than \$500.		
L6884	REPL SOCKT ABOVE ELB DISART MOLD PT	Prior authorization is required when the billed charges are greater than \$500.		
L6885	REPL SOCKT SD/INTRSCAP THOR MOLD PT	Prior authorization is required when the billed charges are greater than \$500.		
L6890	ADD UP EXT PROSTH GLOV TERM PRFAB	Prior authorization is required for billed charges greater than \$500. Reference policies for additional information.	HHO-DE-MP-1031 Myolectric Upper Extremity Orthoses	
L6895	ADD UP EXT PROSTH GLOV TERM CSTM	Prior authorization is required for billed charges greater than \$500. Reference policies for additional information.	HHO-DE-MP-1031 Myolectric Upper Extremity Orthoses	
L6900	HND REST PART W/GLOV THUMB/1 FNGR	Prior authorization is required when the billed charges are greater than \$500.		
L6905	HND REST PART HND W/GLOV MX FNGR	Prior authorization is required when the billed charges are greater than \$500.		
L6910	HND REST PART HND W/GLOV NO FNGR	Prior authorization is required when the billed charges are greater than \$500.		
L6915	HAND REST REPL GLOVE FOR ABOVE	Prior authorization is required when the billed charges are greater than \$500.		
L6920	WRST DISARTC OTTO BOCK/=SWTCH CNTRL	Prior authorization is required when the billed charges are greater than \$500.		
L6925	WRIST DSRTC OTTO BOCK/=MYOELC CNTRL	Prior authorization is required for billed charges greater than \$500. Reference policies for additional information.	HHO-DE-MP-1031 Myolectric Upper Extremity Orthoses	
L6930	BELW ELBOW OTTO BOCK/=SWITCH CNTRL	Prior authorization is required for billed charges greater than \$500. Reference policies for	HHO-DE-MP-1031 Myolectric Upper Extremity Orthoses	
		additional information. Prior authorization is required for billed charges greater than \$500. Reference policies for		
L6935 L6940	BELW ELBOW OTTO BOCK/=MYOELEC CNTRL	additional information.	HHO-DE-MP-1031 Myolectric Upper Extremity Orthoses	
L6940	ELB DISRTC OTTO BOCK/=SWITCH CNTRL	Prior authorization is required when the billed charges are greater than \$500.		
L6945	ELB DISRTC OTTO BOCK/=MYOELC CNTRL	Prior authorization is required for billed charges greater than \$500. Reference policies for additional information.	HHO-DE-MP-1031 Myolectric Upper Extremity Orthoses	
L6950	ABOVE ELB OTTO BOCK/=SWITCH CONTROL	Prior authorization is required when the billed charges are greater than \$500.		
L6955	ABVE ELBOW OTTO BOCK/=MYOELEC CNTRL	Prior authorization is required for billed charges greater than \$500. Reference policies for additional information.	HHO-DE-MP-1031 Myolectric Upper Extremity Orthoses	
L6960	SHLDR DSRTC OTTO BOCK/=SWTCH CNTRL	Prior authorization is required when the billed charges are greater than \$500.		
L6965	SHLDR DSRTC OTTO BOCK/=MYOELC CNTRL	Prior authorization is required for billed charges greater than \$500. Reference policies for additional information.	HHO-DE-MP-1031 Myolectric Upper Extremity Orthoses	
L6970	INTERSCAPULR-THOR OTTO BOCK/=SWITCH	Prior authorization is required when the billed charges are greater than \$500.		
L6975	INTERSCAP-THORAC OTTO BOCK/=MYOELEC	Prior authorization is required for billed charges greater than \$500. Reference policies for additional information.	HHO-DE-MP-1031 Myolectric Upper Extremity Orthoses	
L7007	ELEC HND SWTCH/MYOELEC CNTRL ADULT	Prior authorization is required for billed charges greater than \$500. Reference policies for additional information.	HHO-DE-MP-1031 Myolectric Upper Extremity Orthoses	
L7008	ELEC HAND SWITCH/MYOELEC CNTRL PED	Prior authorization is required for billed charges greater than \$500. Reference policies for additional information.	HHO-DE-MP-1031 Myolectric Upper Extremity Orthoses	
L7009	ELEC HOOK SWITCH/MYOELC CNTRL ADULT	Prior authorization is required for billed charges greater than \$500. Reference policies for additional information.	HHO-DE-MP-1031 Myolectric Upper Extremity Orthoses	
L7040	PREHENSILE ACTUATOR SWITCH CONTROL	Prior authorization is required when the billed charges are greater than \$500.		
L7045	ELEC HOOK SWITCH MYOELEC CONTRL PED	Prior authorization is required when the billed charges are groups and group. Reference policies for additional information.	HHO-DE-MP-1031 Myolectric Upper Extremity Orthoses	
L7170	ELEC ELB HOSMER/EQUAL SWITCH CNTRL	Prior authorization is required when the billed charges are greater than \$500.		
		Prior authorization is required for billed charges greater than \$500. Reference policies for		
L7180	ELEC ELB SEQENTL CNTRL ELB&TRM DEV	additional information.	HHO-DE-MP-1031 Myolectric Upper Extremity Orthoses	
L7181	ELEC ELB SIMULTAN CNTRL ELB&TRM DEV	Prior authorization is required for billed charges greater than \$500. Reference policies for additional information.	HHO-DE-MP-1031 Myolectric Upper Extremity Orthoses	
L7185	ELEC ELB ADOLES VRITY VILL/=SWITCH	Prior authorization is required when the billed charges are greater than \$500.		
L7186	ELEC ELB CHLD VRITY VILL/=SWITCH	Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required for billed charges greater than \$500. Reference policies for	HHO DE MD 1021 Musicetric Linner Schemelik: Ontheren	
L7190	ELEC ELB ADOLES VRITY VILL/=MYOELC	additional information. Prior authorization is required for billed charges greater than \$500. Reference policies for	HHO-DE-MP-1031 Myolectric Upper Extremity Orthoses	
L7191	ELEC ELB CHLD VRITY VILL/=MYOELEC	additional information.	HHO-DE-MP-1031 Myolectric Upper Extremity Orthoses	
L7259 L7360	ELECTRONIC WRIST ROTATOR ANY TYPE SIX VOLT BATTERY EACH	Prior authorization is required when the billed charges are greater than \$500.		
L7360 L7362	SIX VOLI BATTERY EACH BATTERY CHARGER SIX VOLT EACH	Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500.		
L7362 L7364	BATTERY CHARGER SIX VOLT EACH TWELVE VOLT BATTERY EACH	Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500.		
L7364 L7366	BATTERY CHARGER 12 VOLT EACH	Prior authorization is required when the billed charges are greater than \$500.	<u>├</u>	
L7367	LITHIUM ION BATT RECHARGEABLE REPL	Prior authorization is required when the billed charges are greater than \$500.	<u>├</u>	
L7368	LITHIUM ION BATT CHARGER REPL ONLY	Prior authorization is required when the billed charges are greater than \$500.		
L7400	ADD UP EXT PROS BE/WD ULTRALT MATL	Prior authorization is required when the billed charges are greater than \$500.		
L7400	ADD UP EXT PROS ABV ED ULTRALT MATL	Prior authorization is required when the billed charges are greater than \$500.		
L7402	ADD UP EXT PROS SD/INTRSCAP THOR	Prior authorization is required when the billed charges are greater than \$500.		
L7403	ADD UP EXT PROS BE/WD ACRYLIC MATL	Prior authorization is required when the billed charges are greater than \$500.		
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L7404	ADD UP EXT PROS ABVE ED ACRYLC MATL	Prior authorization is required when the billed charges are greater than \$500.		
L7405	ADD UP EXT PROS SD/INTERSCAP THOR	Prior authorization is required when the billed charges are greater than \$500.		
L7499 L7510	Upper extremity prosthesis, not otherwise specified	Prior authorization is required for billed charges greater than \$500. Prior authorization is required for billed charges greater than \$500.		
L7510	Prosthetic repair REPR PROSTH DEVC LABR CMPNT-15 MIN	Prior authorization is required when the billed charges are greater than \$500.		
L7600	PROSETIC DONNING SLEEVE MATERIAL EA	Prior authorization is required when the billed charges are greater than \$500.		
L7700	GKT/SEAL USE PROS SOC INS ANY TY EA	Prior authorization is required when the billed charges are greater than \$500.		
L7900	MALE VACUUM ERECTION SYSTEM	Prior authorization is required when the billed charges are greater than \$500.		
L7902	TENSION RING VAC ERECT DEVC REPL EA	Prior authorization is required when the billed charges are greater than \$500.		
10000	Breast prosthesis, mastectomy bra, without integrated breast prosthesis form, any size,	Prior authorization is required for billed charges greater than \$500. Reference policies for		
L8000	any type	additional information.	HHO-DE-MP-1027 Breast Reconstructive Surgery	
L8001	Breast prosthesis, mastectomy bra, with integrated breast prosthesis form, unilateral, any size, any type	Prior authorization is required for billed charges greater than \$500. Reference policies for additional information.	HHO-DE-MP-1027 Breast Reconstructive Surgery	
L8002	Breast prosthesis, mastectomy bra, with integrated breast prosthesis form, bilateral, any size, any type	Prior authorization is required for billed charges greater than \$500. Reference policies for additional information.	HHO-DE-MP-1027 Breast Reconstructive Surgery	
L8010	Breast prosthesis, mastectomy sleeve	Prior authorization is required for billed charges greater than \$500. Reference policies for additional information.	HHO-DE-MP-1027 Breast Reconstructive Surgery	
L8015	External breast prosthesis garment, with mastectomy form, post mastectomy	Prior authorization is required for billed charges greater than \$500. Reference policies for additional information.	HHO-DE-MP-1027 Breast Reconstructive Surgery	
L8020	Breast prosthesis, mastectomy form	Prior authorization is required for billed charges greater than \$500. Reference policies for additional information.	HHO-DE-MP-1027 Breast Reconstructive Surgery	
L8030	Breast prosthesis, silicone or equal, without integral adhesive	Prior authorization is required for billed charges greater than \$500. Reference policies for additional information.	HHO-DE-MP-1027 Breast Reconstructive Surgery	
L8031	Breast prosthesis, silicone or equal, with integral adhesive	Prior authorization is required for billed charges greater than \$500. Reference policies for additional information.	HHO-DE-MP-1027 Breast Reconstructive Surgery	
L8032	Nipple prosthesis, prefabricated, reusable, any type, each	Prior authorization is required for billed charges greater than \$500. Reference policies for additional information.	HHO-DE-MP-1027 Breast Reconstructive Surgery	
L8033	NIP PRS CSTM FB RUSABL ANY MTL T EA	Prior authorization is required when the billed charges are greater than \$500.		
L8035	Custom breast prosthesis, post mastectomy, molded to patient model	Prior authorization is required for billed charges greater than \$500. Reference policies for additional information.	HHO-DE-MP-1027 Breast Reconstructive Surgery	
L8039	Breast prosthesis, not otherwise specified	Prior authorization is required for billed charges greater than \$500. Reference policies for additional information.	HHO-DE-MP-1027 Breast Reconstructive Surgery	
L8040	NASL PROSTH PROVIDED NON-PHYSICIAN	Prior authorization is required when the billed charges are greater than \$500.		
L8041	MIDFCE PROSTH PROV NON-PHYSICIAN	Prior authorization is required when the billed charges are greater than \$500.		
L8042	ORB PROSTH PROVIDED NON-PHYSICIAN	Prior authorization is required when the billed charges are greater than \$500.		
L8043	UPPER FCE PROSTH PROV NON-PHYSICIAN	Prior authorization is required when the billed charges are greater than \$500.		
L8044	HEMI-FCE PROSTH PROV NON-PHYSICIAN	Prior authorization is required when the billed charges are greater than \$500.		
L8045 L8046	AURICULAR PROSTH PROV NON-PHYSICIAN	Prior authorization is required when the billed charges are greater than \$500.		
L8046 L8047	PART FCE PROSTH PROV NON-PHYSICIAN	Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500.		
L8047 L8048	NASL SEPTAL PROSTH PROV NON-PHYS Unspecified maxillofacial prosthesis, by report, provided by a non-physician	Prior authorization is required when the billed charges are greater than \$500.		-
L8048	REP MAXLOFCE PROS EA 15 MIN NON-MD	Prior authorization is required when the billed charges are greater than \$500.		
L8300	TRUSS SINGLE WITH STANDARD PAD	Prior authorization is required when the billed charges are greater than \$500.		
L8310	TRUSS DOUBLE WITH STANDARD PADS	Prior authorization is required when the billed charges are greater than \$500.		
L8320	TRUSS ADDITION STANDARD PAD H20 PAD	Prior authorization is required when the billed charges are greater than \$500.		
L8330	TRUSS ADD STANDARD PAD SCROTAL PAD	Prior authorization is required when the billed charges are greater than \$500.		
L8400	PROSTHETIC SHEATH BELOW KNEE EACH	Prior authorization is required when the billed charges are greater than \$500.		<u> </u>
L8410	PROSTHETIC SHEATH ABOVE KNEE EACH	Prior authorization is required when the billed charges are greater than \$500.		1
L8415	PROSTHETIC SHEATH UPPER LIMB EACH	Prior authorization is required when the billed charges are greater than \$500.		
L8417	PROS SHEATH/SOCK-GEL CUSHN BK/AK EA	Prior authorization is required when the billed charges are greater than \$500.		
L8420	PROSTHETIC SOCK MX PLY BELW KNEE EA	Prior authorization is required when the billed charges are greater than \$500.		
L8430	PROSTHETIC SOCK MX PLY ABVE KNEE EA	Prior authorization is required when the billed charges are greater than \$500.		
L8435	PROSTH SOCK MX PLY UPPER LIMB EA	Prior authorization is required when the billed charges are greater than \$500.		
L8440	PROSTHETIC SHRINKER BELOW KNEE EACH	Prior authorization is required when the billed charges are greater than \$500.		
L8460	PROSTHETIC SHRINKER ABOVE KNEE EACH	Prior authorization is required when the billed charges are greater than \$500.		
L8465	PROSTHETIC SHRINKER UPPER LIMB EACH	Prior authorization is required when the billed charges are greater than \$500.		
L8470	PROSTH SOCK SINGLE PLY FIT BK EACH	Prior authorization is required when the billed charges are greater than \$500.		
L8480	PROSTH SOCK 1 PLY FIT ABOVE KNEE EA	Prior authorization is required when the billed charges are greater than \$500.		
L8485	PROSTH SOCK 1 PLY FIT UPPER LIMB EA	Prior authorization is required when the billed charges are greater than \$500.		
L8499	Unlisted procedure for miscellaneous prosthetic services	Prior authorization is required for billed charges greater than \$500.		
L8500	ARTIFICIAL LARYNX ANY TYPE	Prior authorization is required when the billed charges are greater than \$500.		
L8501 L8505	TRACHEOSTOMY SPEAKING VALVE ARTFICL LARYNX REPLCMT BATTRY/ACSS	Prior authorization is required when the billed charges are greater than \$500.		
L8505 L8507	ARTFICE LARTINA REPLOYTE BATTRY/ACSS	Prior authorization is required when the billed charges are greater than \$500.		
	TRACHEO_ESODE VOICE PROCED DT INCRT			1
	TRACHEO-ESOPH VOICE PROSTH PT INSRT	Prior authorization is required when the billed charges are greater than \$500.		
L8509	TRACHEO-ESOPH VOICE PROS INSRT PROV	Prior authorization is required when the billed charges are greater than \$500.		
L8509 L8510	TRACHEO-ESOPH VOICE PROS INSRT PROV VOICE AMPLIFIER	Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500.		
L8509	TRACHEO-ESOPH VOICE PROS INSRT PROV	Prior authorization is required when the billed charges are greater than \$500.		

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

		Prior authorization is required for billed charges greater than \$500. Reference policies for	HHO-DE-MP-1190 External Hearing Aids, Auditory Brainstem	
L8691	AO D EXT SP EXCL TRNDCR/ACTR RPL EA	additional information.	Implant, Bone-Anchored Hearing Devices and Audiological	
			Testing	
		Prior authorization is required for billed charges greater than \$500. Reference policies for	HHO-DE-MP-1190 External Hearing Aids, Auditory Brainstem	
L8692	AUDITORY OSSEOINTEGRAT DEV BDY WORN	additional information.	Implant, Bone-Anchored Hearing Devices and Audiological	
			Testing	
L8693	AUD OSSEOINTEGRATED DEVC ABUT REPL	Prior authorization is required when the billed charges are greater than \$500.		
		Drive outpariantian is required for billed charges greater than \$500. Beforence policies for	HHO-DE-MP-1190 External Hearing Aids, Auditory Brainstem	
L8694	AUD OI DVC TRNSDUCR/ACTUATR REPLEA	Prior authorization is required for billed charges greater than \$500. Reference policies for	Implant, Bone-Anchored Hearing Devices and Audiological	
		additional information.	Testing	
L8695	External recharging system for battery (external) for use with implantable neurostimulator,	Prior authorization is required for billed charges greater than \$500. Reference policies for	HHO-DE-MP-1009 Deep Brain Stimulation	
10095	replacement only	additional information.	HHO-DE-WIP-1009 Deep Brain Stimulation	
L8696	ANT FOR IMPL DIA/PN ST DEV REPL EA	Prior authorization is required when the billed charges are greater than \$500.		
L8698	NATION II	Prior authorization is required for billed charges greater than \$500. Reference policies for	HHO-DE-MP-1104 Artificial Hearts and Ventricular Assist	
18698	Miscellaneous component, supply or accessory for use with total artificial heart system	additional information.	Devices	
L8699	Describent's freedoort, and address the second Prod	Prior authorization is required for billed charges greater than \$500. Reference policies for	HHO-DE-MP-1145 Cochlear Implants	
18699	Prosthetic implant, not otherwise specified	additional information.	HHO-DE-MP-1145 Cochlear Implants	
L9900	ORTHO/PROSTH SUPP ACCES &/ SERV	Prior authorization is required when the billed charges are greater than \$500.		
No specific codes listed		Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1205 Testing for Genetic Disease	
			HHO-DE-MP-1132 Skin Replacement Therapy For Chronic Non	
P9020	Platelet rich plasma, each unit	Prior authorization is required. Reference policies for additional information.	healing Wounds in The Outpatient Setting	
			HHO-DE-MP-1132 Skin Replacement Therapy For Chronic Non	
P9022	Red blood cells, washed, each unit	Prior authorization is required. Reference policies for additional information.	healing Wounds in The Outpatient Setting	
Q0138	Injection, ferumoxytol, for treatment of iron deficiency anemia, 1 mg (non-esrd use)	Prior authorization is required.		
	Unspecified oral dosage form, FDA-approved prescription antiemetic, for use as a complete			
Q0181	therapeutic substitute for an IV antiemetic at the time of chemotherapy treatment, not to	Prior authorization is required.		
	exceed a 48-hour dosage regimen			
Q0477	PWR MODULE PT CABL ELEC/PN VAD REPL	Prior authorization is required when the billed charges are greater than \$500.		
Q0478	PWR ADAPTR ELEC/PNEUMAT VAD VEH TYP	Prior authorization is required when the billed charges are greater than \$500.		
Q0479	POWER MODULE ELEC/PNEUMAT VAD REPL	Prior authorization is required when the billed charges are greater than \$500.		
00480	DRIVER FOR PNEUMATIC VAD REPLONLY	Prior authorization is required when the billed charges are greater than \$500.		
Q0481	MICRPROCSS CU FOR ELEC VAD REPL	Prior authorization is required when the billed charges are greater than \$500.		
Q0481 Q0482	MICH ROSS COTOR ELECTRO REPL	Prior authorization is required when the billed charges are greater than \$500.		
Q0482 Q0483	MON/DISPLAY MODULE W/ELEC VAD REPL	Prior authorization is required when the billed charges are greater than \$500.		
Q0483 Q0484	MON/DISPLAY MODULE W/ELEC VAD REPL MON ELEC OR ELEC/PNEUMAT VAD REPL			
Q0485	MON ELEC OR ELEC/PNEUMAT VAD REPL MON CNTRL CABLE FOR ELEC VAD REPL	Prior authorization is required when the billed charges are greater than \$500.		
		Prior authorization is required when the billed charges are greater than \$500.		
Q0486	MON CABLE FOR ELEC/PNEUMAT VAD RE	Prior authorization is required when the billed charges are greater than \$500.		
Q0487	LEADS FOR ANY ELEC/PNEUMAT VAD REPL	Prior authorization is required when the billed charges are greater than \$500.		
Q0488	POWER PACK BASE FOR ELEC VAD REPL	Prior authorization is required when the billed charges are greater than \$500.		
Q0489	PWR PACK BASE ELEC/PNEUMAT VAD RE	Prior authorization is required when the billed charges are greater than \$500.		
Q0490	EMERGENCY PWR SRC FOR ELEC VAD RE	Prior authorization is required when the billed charges are greater than \$500.		
Q0491	EMERG PWR SRC ELEC/PNEUMAT VAD RE	Prior authorization is required when the billed charges are greater than \$500.		
Q0492	EMERG PWR CABLE FOR ELEC VAD REPL	Prior authorization is required when the billed charges are greater than \$500.		
Q0493	EMRG PWR CABL ELEC/PNEUMAT VAD REPL	Prior authorization is required when the billed charges are greater than \$500.		
Q0494	EMERGENCY HAND PUMP REPLACEM NT ONL	Prior authorization is required when the billed charges are greater than \$500.		
Q0495	BATT CHRG ELEC/ELEC-PNEUMAT VAD RPL	Prior authorization is required when the billed charges are greater than \$500.		
Q0496	BATT NOT LITHIUM-ION ELEC VAD REPL	Prior authorization is required when the billed charges are greater than \$500.	1	
Q0497	BATT CLPS ELEC/ELEC-PNEUMAT VAD RPL	Prior authorization is required when the billed charges are greater than \$500.		
Q0498	HOLSTR ELEC/ELEC-PNEUMAT VAD REPL	Prior authorization is required when the billed charges are greater than \$500.		
Q0499	BELT/VEST/BAG ANY TYPE VAD RPL ONLY	Prior authorization is required when the billed charges are greater than \$500.		
Q0500	FLTRS ELEC OR ELEC/PNEUMAT VAD REPL	Prior authorization is required when the billed charges are greater than \$500.		
Q0501	SHOWR COVR ELEC/ELEC/ENECUTION VAD REFE	Prior authorization is required when the billed charges are greater than \$500.		<u> </u>
Q0502	MOBILITY CART FOR PNEUMAT VAD RPL	Prior authorization is required when the billed charges are greater than \$500.		
Q0502 Q0503	BATT FOR PNEUMAT VAD REPL			
		Prior authorization is required when the billed charges are greater than \$500.		
Q0504	PWR ADPTR PNEUMAT VAD REPL VEH TYPE	Prior authorization is required when the billed charges are greater than \$500.		
Q0506	BATT LITHIUM-ION ELEC VAD REPL	Prior authorization is required when the billed charges are greater than \$500.		
Q0507	Miscellaneous supply or accessory for use with an external ventricular assist device	Prior authorization is required for billed charges greater than \$500.		
Q0508	Miscellaneous supply or accessory for use with an implanted ventricular assist device	Prior authorization is required for billed charges greater than \$500.		
Q0509	Miscellaneous supply or accessory for use with any implanted ventricular assist device for	Prior authorization is required for billed charges greater than \$500.		
	which payment was not made under medicare part a			
Q4001	CAST BDY CAST ADLT W/WO HEAD PLAST	Prior authorization is required when the billed charges are greater than \$500.		
Q4002	CAST BDY CAST ADLT W/WO HEAD F-GLSS	Prior authorization is required when the billed charges are greater than \$500.		
Q4003	CAST SPL SHLDR CAST ADULT PLASTR	Prior authorization is required when the billed charges are greater than \$500.		
Q4004	CAST SPL SHLDR CAST ADULT FIBRGLS	Prior authorization is required when the billed charges are greater than \$500.		
Q4005	CAST SPL LONG ARM CAST ADULT PLASTR	Prior authorization is required when the billed charges are greater than \$500.		
		Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500.		
Q4005 Q4006 Q4007	CAST SPL LONG ARM CAST ADULT PLASTR			
Q4005 Q4006	CAST SPL LONG ARM CAST ADULT PLASTR CAST SPL LONG ARM CAST ADLT FIBRGLS	Prior authorization is required when the billed charges are greater than \$500.		

Q4010	CAST SPL SHRT ARM CAST ADLT FIBRGLS	Prior authorization is required when the billed charges are greater than \$500.	
Q4011	CAST SPL SHORT ARM CAST PED PLASTR	Prior authorization is required when the billed charges are greater than \$500.	
Q4012	CAST SPL SHORT ARM CAST PED FIBRGLS	Prior authorization is required when the billed charges are greater than \$500.	
Q4013	CAST SPL GAUNTLT CAST ADULT PLASTR	Prior authorization is required when the billed charges are greater than \$500.	
Q4014	CAST SPL GAUNTLET CAST ADLT F-GLASS	Prior authorization is required when the billed charges are greater than \$500.	
Q4015	CAST SPL GAUNTLT CAST PED PLASTR	Prior authorization is required when the billed charges are greater than \$500.	
Q4016	CAST SPL GAUNTLET CAST PED F-GLASS	Prior authorization is required when the billed charges are greater than \$500.	
Q4010 Q4017	CAST SPL UNG ARM SPLINT ADLT PLASTR	Prior authorization is required when the billed charges are greater than \$500.	
Q4017 Q4018	CAST SPELING ARM SPENT ADLT FORSTR		
		Prior authorization is required when the billed charges are greater than \$500.	
Q4019	CAST SPL LNG ARM SPLINT PED PLASTR	Prior authorization is required when the billed charges are greater than \$500.	
Q4020	CAST SPL LNG ARM SPLINT PED FIBRGLS	Prior authorization is required when the billed charges are greater than \$500.	
Q4021	CAST SPL SHRT ARM SPLINT ADLT PLAST	Prior authorization is required when the billed charges are greater than \$500.	
Q4022	CAST SPL SHRT ARM SPLNT ADLT F-GLSS	Prior authorization is required when the billed charges are greater than \$500.	
Q4023	CAST SPL SHORT ARM SPLINT PED PLAST	Prior authorization is required when the billed charges are greater than \$500.	
Q4024	CAST SPL SHRT ARM SPLNT PED FIBRGLS	Prior authorization is required when the billed charges are greater than \$500.	
Q4025	CAST SPL HIP SPICA ADULT PLASTR	Prior authorization is required when the billed charges are greater than \$500.	
Q4026	CAST SPL HIP SPICA ADULT FIBRGLS	Prior authorization is required when the billed charges are greater than \$500.	
Q4027	CAST SPL HIP SPICA PEDIATRIC PLASTR	Prior authorization is required when the billed charges are greater than \$500.	
Q4028	CAST SPL HIP SPICA PED FIBRGLS	Prior authorization is required when the billed charges are greater than \$500.	
Q4029	CAST SPL LONG LEG CAST ADULT PLASTR		
Q4029 Q4030		Prior authorization is required when the billed charges are greater than \$500.	
	CAST SPL LONG LEG CAST ADLT FIBRGLS	Prior authorization is required when the billed charges are greater than \$500.	
Q4031	CAST SPL LNG LEG CAST PED PLASTR	Prior authorization is required when the billed charges are greater than \$500.	
Q4032	CAST SPL LNG LEG CAST PED FIBRGLS	Prior authorization is required when the billed charges are greater than \$500.	
Q4033	CAST LNG LEG CYCLE CAST ADLT PLAST	Prior authorization is required when the billed charges are greater than \$500.	
Q4034	CAST LNG LEG CYCLE CAST ADLT F-GLSS	Prior authorization is required when the billed charges are greater than \$500.	
Q4035	CAST LNG LEG CYCLE CAST PED PLAST	Prior authorization is required when the billed charges are greater than \$500.	
Q4036	CAST LNG LEG CYCLE CAST PED F-GLSS	Prior authorization is required when the billed charges are greater than \$500.	
Q4037	CAST SPL SHORT LEG CAST ADLT PLASTR	Prior authorization is required when the billed charges are greater than \$500.	
Q4038	CAST SPL SHRT LEG CAST ADLT FIBRGLS	Prior authorization is required when the billed charges are greater than \$500.	
Q4039	CAST SPL SHORT LEG CAST PED PLASTR	Prior authorization is required when the billed charges are greater than \$500.	
Q4035 Q4040	CAST SPL SHORT LEG CAST PED FIBRGLS	Prior authorization is required when the billed charges are greater than \$500.	
Q4040 Q4041	CAST SPL SHORT LEG CAST PED FIBRIES		
		Prior authorization is required when the billed charges are greater than \$500.	
Q4042	CAST SPL LNG LEG SPLNT ADLT FIBRGLS	Prior authorization is required when the billed charges are greater than \$500.	
Q4043	CAST SPL LNG LEG SPLINT PED PLASTR	Prior authorization is required when the billed charges are greater than \$500.	
Q4044	CAST SPL LNG LEG SPLINT PED FIBRGLS	Prior authorization is required when the billed charges are greater than \$500.	
Q4045	CAST SPL SHRT LEG SPLINT ADLT PLAST	Prior authorization is required when the billed charges are greater than \$500.	
Q4046	CAST SPL SHRT LEG SPLNT ADLT F-GLSS	Prior authorization is required when the billed charges are greater than \$500.	
Q4047	CAST SPL SHORT LEG SPLINT PED PLAST	Prior authorization is required when the billed charges are greater than \$500.	
Q4048	CAST SPL SHRT LEG SPLNT PED FIBRGLS	Prior authorization is required when the billed charges are greater than \$500.	
Q4049	FINGER SPLINT STATIC	Prior authorization is required when the billed charges are greater than \$500.	
Q4050	Cast supplies, for unlisted types and materials of casts	Prior authorization is required for billed charges greater than \$500.	
	Splint supplies, miscellaneous (includes thermoplastics, strapping, fasteners, padding and		
Q4051	other supplies)	Prior authorization is required for billed charges greater than \$500.	
	Injection, epoetin alfa, 100 units (for esrd on		
Q4081	dialysis)	Prior authorization is required.	
Q4100	Skin substitute, not otherwise specified	Prior authorization is required.	
		·	HHO-DE-MP-1132 Skin Replacement Therapy For Chronic Non
Q4110	PriMatrix, per sq cm	Prior authorization is required. Reference policies for additional information.	healing Wounds in The Outpatient Setting
			HHO-DE-MP-1132 Skin Replacement Therapy For Chronic Non
Q4111	GammaGraft, per sq cm	Prior authorization is required. Reference policies for additional information.	healing Wounds in The Outpatient Setting
Q4112	Cymetra, injectable, 1 cc	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1132 Skin Replacement Therapy For Chronic Non healing Wounds in The Outpatient Setting
Q4113	GRAFTJACKET XPRESS, injectable, 1 cc	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1132 Skin Replacement Therapy For Chronic Non
			healing Wounds in The Outpatient Setting
Q4115	AlloSkin, per sq cm	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1132 Skin Replacement Therapy For Chronic Non
			healing Wounds in The Outpatient Setting
Q4117	HYALOMATRIX, per sq cm	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1132 Skin Replacement Therapy For Chronic Non
			healing Wounds in The Outpatient Setting
Q4118	MatriStem micromatrix, 1 mg	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1132 Skin Replacement Therapy For Chronic Non
44110	Macrocci micromatrix, 1 mg	The address and the required incidence policies for address all mornation.	healing Wounds in The Outpatient Setting
Q4122	DermACELL, DermACELL AWM or DermACELL AWM Porous, per sq cm	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1132 Skin Replacement Therapy For Chronic Non
Q4122	Demacele, Demacele Awivior Demacele AwiviPorous, per sq cm	Finor autionization is required, reference policies for additional information.	healing Wounds in The Outpatient Setting
04122	All-Chip DT annual an		HHO-DE-MP-1132 Skin Replacement Therapy For Chronic Non
Q4123	AlloSkin RT, per sq cm	Prior authorization is required. Reference policies for additional information.	healing Wounds in The Outpatient Setting
			HHO-DE-MP-1132 Skin Replacement Therapy For Chronic Non
Q4124	OASIS ultra tri-layer wound matrix, per sq cm	Prior authorization is required. Reference policies for additional information.	healing Wounds in The Outpatient Setting
h			HHO-DE-MP-1132 Skin Replacement Therapy For Chronic Non
		Prior authorization is required. Reference policies for additional information.	
Q4125	ArthroFlex, per sq cm	Phot autionization is required. Reference poncies for autitional mormation.	healing Wounds in The Outpatient Setting

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

Q4219	SurgiGRAFT-DUAL, per sq cm	Prior authorization is required.		
Q4221	Amnio Wrap2, per sq cm	Prior authorization is required.		
Q4227	AmnioCoreTM, per sq cm	Prior authorization is required.		
Q4229	Cogenex Amniotic Membrane, per sq cm	Prior authorization is required.		
Q4230	Cogenex Flowable Amnion, per 0.5 cc	Prior authorization is required.		
Q4231	Corplex P, per cc	Prior authorization is required.		1
Q4232	Corplex, per sq cm	Prior authorization is required.		
Q4233	SurFactor or NuDyn, per 0.5 cc	Prior authorization is required.		1
Q4233		Prior authorization is required.		
	XCellerate, per sq cm			
Q4235	AM NIOREPAIR or AltiPly, per sq cm	Prior authorization is required.		
Q4237	Cryo-Cord, per sq cm	Prior authorization is required.		
Q4239	Amnio-Maxx or Amnio-Maxx Lite, per sq cm	Prior authorization is required.		
Q4240	CoreCyte, for topical use only, per 0.5 cc	Prior authorization is required.		
Q4241	PolyCyte, for topical use only, per 0.5 cc	Prior authorization is required.		
Q4242	AmnioCyte Plus, per 0.5 cc	Prior authorization is required.		
Q4244	Procenta, per 200 mg	Prior authorization is required.		
Q4245	AmnioText, per cc	Prior authorization is required.		
Q4246	CoreText or ProText, per cc	Prior authorization is required.		
Q4247	Amniotext patch, per sq cm	Prior authorization is required.		
Q4248		Prior authorization is required.		1
Q4248 Q4249	Dermacyte Amniotic Membrane Allograft, per sq cm			
	AMNIPLY, for topical use only, per sq cm	Prior authorization is required.		
Q4250	AmnioAmp-MP, per sq cm	Prior authorization is required.		1
Q4254	Novafix DL, per sq cm	Prior authorization is required.		
Q4255	REGUaRD, for topical use only, per sq cm	Prior authorization is required.		
Q5009	Hospice or home health care provided in place not otherwise specified (NOS)	Prior authorization is required.		
Q5131	Injection, adalimumab-aacf (idacio), biosimilar, 20 mg	Prior authorization is required.		
Q9991	Injection, buprenorphine extended-release (sublocade), less than or equal to 100 mg	Prior authorization is required.		
Q9992	Injection, buprenorphine extended-release (sublocade), greater than 100 mg	Prior authorization is required.		
S0013	Esketamine, nasal spray, 1 mg	Prior authorization is required.		
S0189	Testosterone pellet, 75 mg	Prior authorization is required.		
S0194	Dialysis/stress vitamin supplement, oral, 100 capsules	Prior authorization is required. Coverage is limited to DSHP+LTSS members who have been diagnosed with HIV/AIDS (B20, B97.35, Z21)		
	Madically induced abortion by evolution of madication induction all accordance or sizes	diagnosed with hit Alb3 (b20, b37.55, 221)		
	Medically induced abortion by oral ingestion of medication including all associated services			
S0199	and supplies (e.g., patient counseling, office visits, confirmation of pregnancy by HCG,	Prior authorization is required. Elective abortions are not covered.		
	ultrasound to confirm duration of pregnancy, ultrasound to confirm completion of abortion)			
	except drugs			
S0215	Nonemergency transportation; mileage, per mile	Reference policies for additional information. the DMMA Provider Portal.		
		https://medicaid.dhss.delaware.gov		
S0500	Disposable contact lens, per lens	Coverage is managed by Davis Vision		
S0512	Daily wear specialty contact lens, per lens	Coverage is managed by Davis Vision		
S0800	Laser in situ keratomileusis (LASIK)	Prior authorization is required and medical necessity criteria must be met.		
50000	Laser in site keretonniedsis (LASIK)	Cosmetic procedures are a non-covered service.		
60010	Distant for the London Long (DDP)	Prior authorization is required and medical necessity criteria must be met.		
S0810	Photorefractive keratectomy (PRK)	Cosmetic procedures are a non-covered service.		1
S1001	DELUXE ITEM PATIENT AWARE	Prior authorization is required when the billed charges are greater than \$500.		
S1002	CUSTOMIZED ITEM	Prior authorization is required when the billed charges are greater than \$500.		1
\$1015	IV TUBING EXTENSION SET	Prior authorization is required when the billed charges are greater than \$500.		1
\$1015 \$1016	NON-PVC IV ADMN SET RX NOT STABLE	Prior authorization is required when the billed charges are greater than \$500.		1
\$1010 \$1030	CONT NONINVAS GLU MON DEVC PURCHASE	Prior authorization is required when the billed charges are greater than \$500.		1
S1031	CONT NONINVAS GLU MON DEVC RENTAL	Prior authorization is required when the billed charges are greater than \$500.		
S1034	ARTIF PANC DEVC SYS CMNCT ALL DEVC	Prior authorization is required when the billed charges are greater than \$500.		1
S1035	SNSR; INVASV DSPBL ART PANC DEVC SYS	Prior authorization is required when the billed charges are greater than \$500.		
S1036	TRANSMTTR;EXT USE ART PANC DEVC SYS	Prior authorization is required when the billed charges are greater than \$500.		
S1037	RECVER; EXT USE ARTIF PANC DEVC SYS	Prior authorization is required when the billed charges are greater than \$500.		
S2053	Transplantation of small intestine and liver allografts	Prior authorization is required.		
S2054	Transplantation of multivisceral organs	Prior authorization is required.		
S2060	Lobar lung transplantation	Prior authorization is required.		
\$2061	Donor lobectomy (lung) for transplantation, living donor	Prior authorization is required.		
S2061		Prior authorization is required.		
\$2061 \$2065	Simultaneous pancreas kidney transplantation			
	Adjustment of gastric band diameter via subcutaneous port by injection or	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1004 Bariatric Surgery	
S2065	Adjustment of gastric band diameter via subcutaneous port by injection or aspiration of saline	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1004 Bariatric Surgery	
S2065 S2083	Adjustment of gastric band diameter via subcutaneous port by injection or aspiration of saline Islet cell tissue transplant from pancreas; allogeneic	·	HHO-DE-MP-1004 Bariatric Surgery	
S2065 S2083	Adjustment of gastric band diameter via subcutaneous port by injection or aspiration of saline Islet cell tissue transplant from pancreas; allogeneic Bone marrow or blood-derived stem cells (peripheral or umbilical), allogeneic or	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1004 Bariatric Surgery	
\$2065 \$2083 \$2102	Adjustment of gastric band diameter via subcutaneous port by injection or aspiration of saline Islet cell tissue transplant from pancreas; allogeneic Bone marrow or blood-derived stem cells (peripheral or umbilical), allogeneic or autologous, harvesting, transplantation and related complications; including: pheresis and	Prior authorization is required. Reference policies for additional information. Prior authorization is required.	HHO-DE-MP-1004 Bariatric Surgery	
S2065 S2083	Adjustment of gastric band diameter via subcutaneous port by injection or aspiration of saline Islet cell tissue transplant from pancreas; allogeneic Bone marrow or blood-derived stem cells (peripheral or umbilical), allogeneic or autologous, harvesting, transplantation and related complications; including: pheresis and cell preparation/storage; marrow ablative therapy; drugs, supplies, hospitalization with	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1004 Bariatric Surgery	
S2065 S2083 S2102	Adjustment of gastric band diameter via subcutaneous port by injection or aspiration of saline Islet cell tissue transplant from pancreas; allogeneic Bone marrow or blood-derived stem cells (peripheral or umbilical), allogeneic or autologous, harvesting, transplantation and related complications; including: pheresis and	Prior authorization is required. Reference policies for additional information. Prior authorization is required.	HHO-DE-MP-1004 Bariatric Surgery	

	Solid organ(s), complete or segmental, single organ or combination of organs; deceased or			
	living donor(s), procurement, transplantation and related complications; including: drugs;			
S2152	supplies; hospitalization with outpatient follow-up; medical/surgical, diagnostic,	Prior authorization is required.		
	emergency and rehabilitative services and the number of days of pre- and posttransplant			
	care in the global definition			
S2260	Induced abortion, 17 to 24 weeks	Prior authorization is required. Elective abortions are not covered.		
S2265	Induced abortion, 25 to 28 weeks	Prior authorization is required. Elective abortions are not covered.		
S2266	Induced abortion, 29 to 31 weeks	Prior authorization is required. Elective abortions are not covered.		
S2267	Induced abortion, 32 weeks or greater	Prior authorization is required. Elective abortions are not covered.		
32287	Induced abortion, 32 weeks of greater	Phor authorization is required. Elective abortions are not covered.		
S2405	Repair of sacrococcygeal teratoma in the fetus, procedure performed in utero	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1110 Fetal Surgery for Prenatally Diagnosed Malformations	
S3854	Gene expression profiling panel for use in the management of breast cancer treatment	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1210 Oncologic Genetic Testing Panels	
\$5101	Day care services, adult; per half day	Prior authorization is required. Coverage is limited to DSHP+LTSS members who do not reside in a assisted living or nursing facility. Meals are not seperately reimbursable.		
S5101-U1	Day care services, adult; per half day-Enhanced Services	Prior authorization is required. Coverage is limited to DSHP+LTSS members who do not reside in a assisted living or nursing facility. Meals are not seperately reimbursable.		
\$5105	Day care services, center-based; services not included in program fee, per diem	Prior authorization is required. Coverage is limited to DSHP+LTSS members who do not reside in a assisted living or nursing facility. Meals are not seperately reimbursable.		
	Day care services, center-based; services not included in program fee, per diem-Enhanced			1
S5105-U1	Services	a assisted living or nursing facility. Meals are not seperately reimbursable.		
S5120	Chore services; per 15 minutes	Prior authorization is required. Coverage is limited to DSHP+ LTSS members.		1
\$5125		Prior authorization is required. Coverage is limited to DSHP+LTSS members.		1
	Attendant care services; per 15 minutes			
S5130	Self-Directed Attendant Care Services, per 15 minutes	Prior authorization is required. Reference policies for additional information.	HHO-DE-RP-1133 Self-Directed Attendant Care-Non LTSS	
S5150	Unskilled respite care, not hospice; per 15 minutes	Prior authorization is required. Reference policies for additional information.	HHO-DE-RP-1135 Respite Care-Pediatric	
S5151	Unskilled respite care, not hospice; per diem	Prior authorization is required. Reference policies for additional information.	HHO-DE-RP-1135 Respite Care-Pediatric	
S5160	Emergency response system; installation and testing	Prior authorization is required. Coverage is limited to DSHP+LTSS members who do not reside in an assisted living or nursing facility.		
		Prior authorization is required. Coverage is limited to DSHP+LTSS members who do not reside in		
\$5161	Emergency response system; service fee, per month (excludes installation and testing)	an assisted living or nursing facility.		
\$5162	Emergency response system; purchase only	Prior authorization is required. Coverage is limited to DSHP+LTSS members who do not reside in an assisted living or nursing facility.		
\$5165	Home modifications; per service	Prior authorization is required. Coverage is limited to DSHP+LTSS members who do not reside in an assisted living or nursing facility.		
\$5170	Home delivered meals, including preparation; per meal (fresh)	Prior authorization is required. Coverage is limited to two meals per day.		
S5170-ET	Home delivered meals, including preparation; per meal (emergency meal)	Prior authorization is required. Coverage is limited to two meals per day.		
S5170-U1	Home delivered meals, including preparation; per meal (frozen)	Prior authorization is required. Coverage is limited to two meals per day.		
S8030	Scleral application of tantalum ring(s) for localization of lesions for proton beam therapy	Prior authorization is required.		
\$8037	Magnetic resonance cholangiopancreato-graphy (MRCP)	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
\$8042	Magnetic Resonance Imaging (MRI), Low-Field	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
\$8092	Electron Beam Computed Tomography (Also Known As Ultrafast CT, CINET)	Prior authorization is managed by EviCore.		Prior authorization is managed by EviCore.
\$8096				
		Prior authorization is required when the billed charges are greater than \$500		Evicone.
\$8097	PORTABLE PEAK FLOW METER	Prior authorization is required when the billed charges are greater than \$500.		Evicoic.
	ASTHMA KIT	Prior authorization is required when the billed charges are greater than \$500.		
S8100	ASTHMA KIT HOLD CHAMB W/INHAL/NEBULIZR;NO MASK	Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500.		
S8101	ASTHMA KIT HOLD CHAMB W/INHAL/NEBULIZR;NO MASK HOLD CHAMB W/INHAL/NEBULIZR; W/MASK	Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500.		
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\$8101 \$8110 \$8120 \$8121 \$8130 \$8131 \$8185 \$8186 \$8189 \$8210 \$8220 \$8270 \$8301 \$8415 \$8420 \$8421 \$8422 \$8423 \$8424 \$8425	ASTHMA KIT HOLD CHAMB W/INHAL/NEBULIZR; NO MASK HOLD CHAMB W/INHAL/NEBULIZR; W/MASK PEAK EXPIRATORY FLOW NATE O.2 CNTN GASEOUS 1 U = 1 CUBIC FOOT O.2 CONTENTS LQD 1 U E QUALS 1 PO UND INTERFERENTIAL CURR STIM 2 CHANNEL INTERFERENTIAL CURR STIM 2 CHANNEL INTERFERENTIAL CURR STIM 2 CHANNEL FLUTTER DEVICE SWIVEL ADAPTOR TRACHEOSTOMY SUPPLY NOC MUCUS TRAP HABERMAN FEEDER CLEFT UP/PALATE ENURESIS ALARM BUZZZ/VIBRATION DEVC INFECTION CONTROL SUPPLIES NOS SUPPLIES HOME DELIVERY OF INFANT GRADENT PRESS AID SLEEVE READY MADE GRADENT PRESS AID SLEEV CSTM MED WT GRADENT PRESS AID SLEEVE CSTM MED WT GRADENT PRESS AID SLEEVE CSTM MED WT GRADENT PRESS AID SLEEVE CSTM MADE GRADENT PRESS AID SLEEVE CSTM MED WT GRADENT PRESS AID SLEEVE CSTM MED WT	Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500. Prior authorization is required when the billed charges are greater than \$500.		
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\$8428	GRADENT PRESS AID GAUNTLET RDY MADE	Prior authorization is required when the billed charges are greater than \$500.		
S8429	GRADIENT PRESSURE EXTERIOR WRAP	Prior authorization is required when the billed charges are greater than \$500.		
S8430	PADDING COMPRESSION BANDAGE ROLL	Prior authorization is required when the billed charges are greater than \$500.		
\$8431	COMPRESSION BANDAGE ROLL	Prior authorization is required when the billed charges are greater than \$500.		
S8450	SPLINT PREFABRICATED DIGIT	Prior authorization is required when the billed charges are greater than \$500.		
\$8451	SPLINT PREFABRICATED WRIST OR ANKLE	Prior authorization is required when the billed charges are greater than \$500.		
\$8452	SPLINT PREFABRICATED ELBOW	Prior authorization is required when the billed charges are greater than \$500.		
S8460	CAMISOLE POST-MASTECTOMY	Prior authorization is required when the billed charges are greater than \$500.		
S8490	INSULIN SYRINGES	Prior authorization is required when the billed charges are greater than \$500.		
S8999	RESUSCITATION BAG	Prior authorization is required when the billed charges are greater than \$500.		
\$9001	HOME UTERIN MON W/WO ASSOC NRS SRVC	Prior authorization is required when the billed charges are greater than \$500.		
S9007	ULTRAFILTRATION MONITOR	Prior authorization is required when the billed charges are greater than \$500.		
\$9123	Nursing care, in the home; by registered nurse, per hour	Prior authorization is required.		
\$9124	Nursing care, in the home; by licensed practical nurse, per hour	Prior authorization is required.		
\$9125	Respite care, in the home, per diem	Prior authorization is required. Reference policies for additional information.	HHO-DE-RP-1135 Respite Care-Pediatric	
\$9433	MED FOOD NUTR ORAL 100% NUTR INTAKE	Prior authorization is required when the billed charges are greater than \$500.		
\$9434	MOD SOLID FOOD SUP INBORN ERR METAB	Prior authorization is required when the billed charges are greater than \$500.		
S9435	MEDICAL FOODS INBORN ERRORS METAB	Prior authorization is required when the billed charges are greater than \$500.		
S9470	Nutritional counseling, dietitian visit	Prior authorization is required. Reference policies for additional information.	HHO-DE-MP-1133 Medical Nutrition Management Services	
\$9988	Services provided as part of a Phase I clinical trial	Prior authorization is required. Reference policies for additional information.	HHO-DE-RP-DE-1141 Clinical Trial	
\$9990	Services provided as part of a Phase II clinical trial	Prior authorization is required. Reference policies for additional information.	HHO-DE-RP-DE-1141 Clinical Trial	
\$9991	Services provided as part of a Phase III clinical trial	Prior authorization is required. Reference policies for additional information.	HHO-DE-RP-DE-1141 Clinical Trial	
T1000	Private duty/independent nursing service(s), licensed, up to 15 minutes	Prior authorization is required.		
T1001	Nursing assessment/evaluation	Prior authorization is required.		
T1002	RN services, up to 15 minutes	Prior authorization is required.		
T1005	Respite care services, up to 15 minutes	Prior authorization is required. Reference policies for additional information.	HHO-DE-RP-1135 Respite Care-Pediatric	
T2001	Nonemergency transportation; patient attendant/escort	Reference policies for additional information. the DMMA Provider Portal.		
	• • • •	https://medicaid.dhss.delaware.gov		
T2002	Nonemergency transportation; per diem	Reference policies for additional information. the DMMA Provider Portal.		
		https://medicaid.dhss.delaware.gov Reference policies for additional information. the DMMA Provider Portal.		
T2003	Nonemergency transportation; encounter/trip			
		https://medicaid.dhss.delaware.gov Reference policies for additional information. the DMMA Provider Portal.		
T2004	Nonemergency transport; commercial carrier, multipass	https://medicaid.dhss.delaware.gov		
		Reference policies for additional information. the DMMA Provider Portal.		
T2005	Nonemergency transportation; stretcher van	https://medicaid.dhss.delaware.gov		
	Transportation waiting time, air ambulance and nonemergency vehicle, one-half (1/2) hour	Reference policies for additional information. the DMMA Provider Portal.		
T2007	increments	https://medicaid.dhss.delaware.gov		
		Prior authorization is required. Coverage is limited to DSHP+ LTSS members. Not available to		
T2020	Day habilitation, waiver; per diem	members living in non-ABI assisted living and nursing facilities.		
T2028	Specialized supply, not otherwise specified, waiver	Prior authorization is required for billed charges greater than \$500.		
T2029	Specialized medical equipment, not otherwise specified, waiver	Prior authorization is required for billed charges greater than \$500.		
		Prior authorization is required. Coverage is limited to DSHP+LTSS members.		
		There is a financial limit of \$2,500.00 per transition, this may be used for covering housing		
73030		application fees security deposit, utilities home furnishings and household essentials including		
T2038	Community transition, waiver; per service	food supplies. This assistance can be provided through connecting the member to community		
		resources or directly by the Contractor. These items are not billed directly to HHO, the Nursing		
		Facility Transition CM utilizes an expense card.		
T20.40		Reference policies for additional information. the DMMA Provider Portal.		
T2049	Nonemergency transportation; stretcher van, mileage; per mile	https://medicaid.dhss.delaware.gov		
T45.21		Prior authorization is required if more than 8 units are billed per day.		
T4521	Adult sized disposable incontinence product, brief/diaper, small, each	Not a covered service for members ages 3 and younger.		
T4522	Adult sized disposable incontinence product brief/dispose modium and	Prior authorization is required if more than 8 units are billed per day.		
14522	Adult sized disposable incontinence product, brief/diaper, medium, each	Not a covered service for members under 4.		
T4523	Adult sized disposable incontinence product, brief/diaper, large, each	Prior authorization is required if more than 8 units are billed per day.		-
14323	Addit sized disposable incontinence product, brief/diaper, large, each	Not a covered service for members under 4.		
T4524	Adult sized disposable incontinence product, brief/diaper, extra large, each	Prior authorization is required if more than 8 units are billed per day.		
17324	, date sized disposable incontinence product, brief/ diaper, extra large, edch	Not a covered service for members under 4.		
T4525	Adult sized disposable incontinence product, protective underwear/pull-on, small size, each	Prior authorization is required if more than 8 units are billed per day.		
		Not a covered service for members under 4.		
T4526	Adult sized disposable incontinence product, protective underwear/pull-on, medium size,	Prior authorization is required if more than 8 units are billed per day.		
	each	Not a covered service for members under 4.		
1	Adult sized disposable incontinence product, protective underwear/pull-on, large size, each	Prior authorization is required if more than 8 units are billed per day.		
T4527		Not a covered service for members under 4.		
T4527				
T4527 T4528	Adult sized disposable incontinence product, protective underwear/pull-on, extra large size,	Prior authorization is required if more than 8 units are billed per day.		
		Prior authorization is required if more than 8 units are billed per day. Not a covered service for members under 4.		
	Adult sized disposable incontinence product, protective underwear/pull-on, extra large size,	Prior authorization is required if more than 8 units are billed per day.		

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T4530	Pediatric sized disposable incontinence product, brief/diaper, large size, each	Prior authorization is required if more than 8 units are billed per day. Not a covered service for members under 4.	
T4531	Pediatric sized disposable incontinence product, protective underwear/pull-on,	Prior authorization is required if more than 8 units are billed per day.	
14531	small/medium size, each	Not a covered service for members under 4.	
T4532	Pediatric sized disposable incontinence product, protective underwear/pull-on, large size, each	Prior authorization is required if more than 8 units are billed per day. Not a covered service for members under 4.	
T4533	Youth sized disposable incontinence product, brief/diaper, each	Prior authorization is required if more than 8 units are billed per day. Not a covered service for members under 4.	
T4534	Youth sized disposable incontinence product, protective underwear/pull-on, each	Prior authorization is required if more than 8 units are billed per day. Not a covered service for members under 4.	
T4535	Disposable liner/shield/guard/pad/undergarment, for incontinence, each	Prior authorization is required if more than 8 units are billed per day.	
T4541	Incontinence product, disposable underpad, large, each	Prior authorization is required if more than 8 units are billed per day.	
T4542	Incontinence product, disposable underpad, small size, each	Prior authorization is required if more than 8 units are billed per day.	
T4543	Adult sized disposable incontinence product, protective brief/diaper, above extra large, each	Prior authorization is required if more than 8 units are billed per day. Not a covered service for members under 4.	
T4544	Adult sized disposable incontinence product, protective underwear/pull-on, above extra large, each	Prior authorization is required if more than 8 units are billed per day. Not a covered service for members under 4.	
T4545	Incontinence product, disposable, penile wrap, each	Prior authorization is required if more than 8 units are billed per day.	
T5999	Supply, not otherwise specified	Prior authorization is required for billed charges greater than \$500.	
V2020	Frames, purchases	Coverage is managed by Davis Vision	
V2025	Deluxe frame	Coverage is managed by Davis Vision	
V2100	Sphere, single vision, plano to plus or minus 4.00, per lens	Coverage is managed by Davis Vision	
V2101	Sphere, single vision, plus or minus 4.12 to plus or minus 7.00d, per lens	Coverage is managed by Davis Vision	
V2102	Sphere, single vision, plus or minus 7.12 to plus or minus 20.00d, per lens	Coverage is managed by Davis Vision	
V2103	Spherocylinder, single vision, plano to plus or minus 4.00d sphere, 0.12 to 2.00d cylinder, per lens	Coverage is managed by Davis Vision	
V2104	Spherocylinder, single vision, plano to plus or minus 4.00d sphere, 2.12 to 4.00d cylinder, per lens	Coverage is managed by Davis Vision	
V2105	Spherocylinder, single vision, plano to plus or minus 4.00d sphere, 4.25 to 6.00d cylinder, per lens	Coverage is managed by Davis Vision	
V2106	Spherocylinder, single vision, plano to plus or minus 4.00d sphere, over 6.00d cylinder, per lens	Coverage is managed by Davis Vision	
V2107	Spherocylinder, single vision, plus or minus 4.25 to plus or minus 7.00 sphere, 0.12 to 2.00d cylinder, per lens	Coverage is managed by Davis Vision	
V2108	Spherocylinder, single vision, plus or minus 4.25d to plus or minus 7.00d sphere, 2.12 to 4.00d cylinder, per lens	Coverage is managed by Davis Vision	
V2109	Spherocylinder, single vision, plus or minus 4.25 to plus or minus 7.00d sphere, 4.25 to 6.00d cylinder, per lens	Coverage is managed by Davis Vision	
V2110	Spherocylinder, single vision, plus or minus 4.25 to 7.00d sphere, over 6.00d cylinder, per lens	Coverage is managed by Davis Vision	
V2111	Spherocylinder, single vision, plus or minus 7.25 to plus or minus 12.00d sphere, 0.25 to 2.25d cylinder, per lens	Coverage is managed by Davis Vision	
V2112	Spherocylinder, single vision, plus or minus 7.25 to plus or minus 12.00d sphere, 2.25d to 4.00d cylinder, per lens	Coverage is managed by Davis Vision	
V2113	Spherocylinder, single vision, plus or minus 7.25 to plus or minus 12.00d sphere, 4.25 to 6.00d cylinder, per lens	Coverage is managed by Davis Vision	
V2114	Spherocylinder, single vision, sphere over plus or minus 12.00d, per lens	Coverage is managed by Davis Vision	
V2115	Lenticular (myodisc), per lens, single vision	Coverage is managed by Davis Vision	
V2118	Aniseikonic lens, single vision	Coverage is managed by Davis Vision	
V2121	Lenticular lens, per lens, single	Coverage is managed by Davis Vision	
V2199	Not otherwise classified, single vision lens	Coverage is managed by Davis Vision	
V2200	Sphere, bifocal, plano to plus or minus 4.00d, per lens	Coverage is managed by Davis Vision	
V2201	Sphere, bifocal, plus or minus 4.12 to plus or minus 7.00d, per lens	Coverage is managed by Davis Vision	
V2202	Sphere, bifocal, plus or minus 7.12 to plus or minus 20.00d, per lens	Coverage is managed by Davis Vision	
V2203	Spherocylinder, bifocal, plano to plus or minus 4.00d sphere, 0.12 to 2.00d cylinder, per lens	Coverage is managed by Davis Vision	
V2204	Spherocylinder, bifocal, plano to plus or minus 4.00d sphere, 2.12 to 4.00d cylinder, per lens	Coverage is managed by Davis Vision	
V2205	Spherocylinder, bifocal, plano to plus or minus 4.00d sphere, 4.25 to 6.00d cylinder, per lens	Coverage is managed by Davis Vision	
V2206	Spherocylinder, bifocal, plano to plus or minus 4.00d sphere, over 6.00d cylinder, per lens	Coverage is managed by Davis Vision	
V2207	Spherocylinder, bifocal, plus or minus 4.25 to plus or minus 7.00d sphere, 0.12 to 2.00d cylinder, per lens	Coverage is managed by Davis Vision	
V2208	Spherocylinder, bifocal, plus or minus 4.25 to plus or minus 7.00d sphere, 2.12 to 4.00d cylinder, per lens	Coverage is managed by Davis Vision	
V2209	Spherocylinder, bifocal, plus or minus 4.25 to plus or minus 7.00d sphere, 4.25 to 6.00d cylinder, per lens	Coverage is managed by Davis Vision	
V2210	Spherocylinder, bifocal, plus or minus 4.25 to plus or minus 7.00d sphere, over 6.00d cylinder, per lens	Coverage is managed by Davis Vision	
V2211	Spherocylinder, bifocal, plus or minus 7.25 to plus or minus 12.00d sphere, 0.25 to 2.25d cylinder, per lens	Coverage is managed by Davis Vision	
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V2212	Spherocylinder, bifocal, plus or minus 7.25 to plus or minus 12.00d sphere, 2.25 to 4.00d cylinder, per lens	Coverage is managed by Davis Vision		
V2213	Spherocylinder, bifocal, plus or minus 7.25 to plus or minus 12.00d sphere, 4.25 to 6.00d cylinder, per lens	Coverage is managed by Davis Vision		
V2214	Spherocylinder, bifocal, sphere over plus or minus 12.00d, per lens	Coverage is managed by Davis Vision		
V2215	Lenticular (myodisc), per lens, bifocal	Coverage is managed by Davis Vision		
V2218	Aniseikonic, per lens, bifocal	Coverage is managed by Davis Vision		
V2210	Bifocal seg width over 28mm	Coverage is managed by Davis Vision		
V2220	Bifocal add over 3.25d	Coverage is managed by Davis Vision		
V2220 V2221				
	Lenticular lens, per lens, bifocal	Coverage is managed by Davis Vision		
V2299	Specialty bifocal (by report)	Coverage is managed by Davis Vision		
V2300	Sphere, trifocal, plano to plus or minus 4.00d, per lens	Coverage is managed by Davis Vision		
V2301	Sphere, trifocal, plus or minus 4.12 to plus or minus 7.00d per lens	Coverage is managed by Davis Vision		
V2302	Sphere, trifocal, plus or minus 7.12 to plus or minus 20.00, per lens	Coverage is managed by Davis Vision		
V2304	Spherocylinder, trifocal, plano to plus or minus 4.00d sphere, 2.25 to 4.00d cylinder, per lens	Coverage is managed by Davis Vision		
V2305	Spherocylinder, trifocal, plano to plus or minus 4.00d sphere, 4.25 to 6.00 cylinder, per lens	Coverage is managed by Davis Vision		
V2306	Spherocylinder, trifocal, plano to plus or minus 4.00d sphere, over 6.00d cylinder, per lens	Coverage is managed by Davis Vision		
V2307	Spherocylinder, trifocal, plus or minus 4.25 to plus or minus 7.00d sphere, 0.12 to 2.00d cylinder, per lens	Coverage is managed by Davis Vision		
V2308	Spherocylinder, trifocal, plus or minus 4.25 to plus or minus 7.00d sphere, 2.12 to 4.00d cylinder, per lens	Coverage is managed by Davis Vision		
	Spherocylinder, trifocal, plus or minus 4.25 to plus or minus 7.00d sphere, 4.25 to 6.00d			
V2309	cylinder, per lens	Coverage is managed by Davis Vision		
V2310	Spherocylinder, trifocal, plus or minus 4.25 to plus or minus 7.00d sphere, over 6.00d cylinder, per lens	Coverage is managed by Davis Vision		
V2311	Spherocylinder, trifocal, plus or minus 7.25 to plus or minus 12.00d sphere, 0.25 to 2.25d cylinder, per lens	Coverage is managed by Davis Vision		
V2312	Spherocylinder, trifocal, plus or minus 7.25 to plus or minus 12.00d sphere, 2.25 to 4.00d cylinder, per lens	Coverage is managed by Davis Vision		
V2313	Spherocylinder, trifocal, plus or minus 7.25 to plus or minus 12.00d sphere, 4.25 to 6.00d cylinder, per lens	Coverage is managed by Davis Vision		
V2314	Spherocylinder, trifocal, sphere over plus or minus 12.00d, per lens	Coverage is managed by Davis Vision		
V2315	Lenticular, (myodisc), per lens, trifocal	Coverage is managed by Davis Vision		
V2318	Aniseikonic lens, trifocal	Coverage is managed by Davis Vision		
V2319	Trifocal seg width over 28 mm	Coverage is managed by Davis Vision		
V2320	Trifocal add over 3.25d	Coverage is managed by Davis Vision		
V2321	Lenticular lens, per lens, trifocal	Coverage is managed by Davis Vision		
V2399	Specialty trifocal (by report)	Coverage is managed by Davis Vision		
V2500	Contact lens, PMMA, spherical, per lens	Coverage is managed by Davis Vision		
V2501	Contact lens, PMMA, toric or prism ballast, per lens	Coverage is managed by Davis Vision		
V2502	Contact lens PMMA, bifocal, per lens	Coverage is managed by Davis Vision		
V2503	Contact lens, PMMA, color vision deficiency, per lens	Coverage is managed by Davis Vision		
V2510	Contact lens, gas permeable, spherical, per lens	Coverage is managed by Davis Vision		
V2510 V2511	Contact lens, gas permeable, toric, prism ballast, per lens	Coverage is managed by Davis Vision		
V2511 V2512	Contact lens, gas permeable, bifocal, per lens	Coverage is managed by Davis Vision		
V2512 V2513	Contact lens, gas permeable, bildcal, per lens	Coverage is managed by Davis Vision		
V2513	Contact lens, by drophilic, spherical, per lens	Coverage is managed by Davis Vision		
V2520	Contact lens, hydrophilic, toric, or prism ballast, per lens	Coverage is managed by Davis Vision		
V2521 V2522	Contact lens, hydrophilic, toric, or prism ballast, per lens Contact lens, hydrophilic, bifocal, per lens	Coverage is managed by Davis vision Coverage is managed by Davis Vision		
V2522 V2523	Contact lens, hydrophilic, bitocal, per lens	Coverage is managed by Davis Vision		
V2523 V2530	Contact iens, nyaropnilic, extended wear, per iens Contact lens, scleral, gas impermeable, per iens (for contact iens modification, see 92325)	Coverage is managed by Davis Vision		
V2531	Contact lens, scleral, gas permeable, per lens (for contact lens modification, see 92325)	Coverage is managed by Davis Vision		
V2599	Contact lens, other type	Coverage is managed by Davis Vision		
V2784	Lens, polycarbonate or equal, any index, per lens	Coverage is managed by Davis Vision		
V2790	Amniotic membrane for surgical reconstruction, per procedure	Prior authorization is required.		
V5030	HEAR AID MONAURL BDY WRN AIR CONDCT	Prior authorization is required for billed charges greater than \$500. Reference policies for additional information.	HHO-DE-MP-1190 External Hearing Aids, Auditory Brainstem Implant, Bone-Anchored Hearing Devices and Audiological Testing and HHO-DE-MP-1140 Coverage for Hearing Aids	
V5040	HEAR AID MONAURL BDY WORN BN CONDCT	Prior authorization is required for billed charges greater than \$500. Reference policies for additional information.	HHO-DE-MP-1190 External Hearing Aids, Auditory Brainstem Implant, Bone-Anchored Hearing Devices and Audiological Testing and HHO-DE-MP-1140 Coverage for Hearing Aids	
V5050	HEARING AID MONAURAL IN THE EAR	Prior authorization is required for billed charges greater than \$500. Reference policies for additional information.	HHO-DE-MP-1190 External Hearing Aids, Auditory Brainstem Implant, Bone-Anchored Hearing Devices and Audiological Testing and HHO-DE-MP-1140 Coverage for Hearing Aids	

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

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

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