CPT/HCPCS Code List for Commercial and Medicare Advantage Prior Approval

Prior authorization for the services listed are required for both Commercial and Medicare Advantage plans unless otherwise specified in the special instruction column.

The terms prior authorization, prior approval, predetermination, precertification all refers to the same process.

For all services and procedures in this prior authorization list, Medical Mutual contracted providers must submit prior authorization requests via the web. Only non-contracted providers can submit prior authorization requests via fax.

- Prior authorization for the services listed is required for both Commercial and Medicare Advantage plans unless otherwise specified in the special instruction column in the list below.
- This code listing does not certify benefits or authorization of benefits, which is designated by each individual policyholder terms, conditions, exclusions, and limitations contract. It does not constitute a contract or guarantee regarding coverage or reimbursement/payment.
  - Self-insured group specific policy will supersede this general policy when group supplementary plan document or individual plan decision directs otherwise.
- Services that are potentially cosmetic due to diagnosis require prior authorization.
- All genetic testing requires prior authorization.
  - All inpatient admissions require prior authorization.
- All Category III codes require prior authorization.
- Any unlisted or non-specific codes require prior authorization.

Please submit requests for Medical Mutual managed codes to:
Care Management: Web: https://login.coherehealth.com or Fax: 1-800-221-2640 (Medicare Advantage), 1-877-321-6664 (Commercial)
https://www.medmutual.com/-/media/MedMutual/Files/Providers/Forms/PriorApprovalForm.pdf

Outpatient Services (Furnished in a physician office, certified ambulatory surgery center, outpatient hospital or any other location)
Ambulance services, DME, Gene Expression/Microarray Analysis, Other Medical/Surgical/Diagnostic Services, Reconstructive procedures, Surgical Procedures, Private Duty Nursing, Other additional services

Medical/Surgical Acute Care Admissions and Medical/Surgical Post-Acute Admissions: Acute Physical Rehabilitation, Long Term Acute Care (LTAC) Skilled Nursing Facility (SNF)
Medical Mutual contracting providers submit through MedCommunity at https://mmo-prd-pportal.assurecaremc.com/login. For all other providers please fax commercial clinical information to 1-800-517-2583 and Medicare Advantage clinical information to 1-800-221-2640.
Acute Physical Rehabilitation, Long Term Acute Care (LTAC) Skilled Nursing Facility (SNF). Prior approval of normal deliveries is not required unless the length of stay for the mother or child exceeds 48 hours for vaginal delivery or 96 hours for C-section.

Behavioral Health Admissions-Acute Care Psychiatric/Substance Abuse Residential Inpatient:
Medical Mutual contracting providers submit through MedCommunity at https://mmo-prd-pportal.assurecaremc.com/login. For all other providers, please fax all clinical information to 1-800-524-9817.
Acute Care Psychiatric/Substance Abuse Residential Inpatient

Transplant:
Please call Care Management for all transplant requests Phone: 1-800-258-3175
Transplantation – • Blood component (e.g., Stem Cell, Bone Marrow) • Solid Organ (Except Corneal) • Pancreatic Islet Cell - Autologous

Home Healthcare Services (All)
No prior authorization is required for home health care services. The provider is responsible to ensure that home care services are medically necessary to be considered a covered service.

Investigational / Experimental Services:
The health plan defines investigational procedures, therapies, devices and supplies as services that are not approved by governing bodies OR do not demonstrate comparable or superior outcomes to current practice standards as evidenced by peer-reviewed published literature and/or clinical trials. Please refer to our Corporate Medical Policies for Investigational/Experimental Services.

Please submit Cohere managed services: Chiropratic, Therapy, Radiology/Imaging, Cardiology, GI, and Sleep (including DME) service requests to:
Cohere Health Web: https://login.coherehealth.com Fax: (570) 684-4168 Phone: (855) 482-3649
Speech, physical occupational and chiropractic services. Ablations Cardiac devices Electrophysiology studies Cardiac Catheterization and interventions Sleep studies Oral appliances CPAPS Capsule endoscopy EGDs Hernia repairs
Imaging Computed Tomography (CT) Magnetic Resonance Imaging/Angiography (MRI/MRA) Myocardial perfusion (SPECT/PET) and cardiac blood pool imaging Other Nuclear Medicine Position Emission Tomography (PET)

Please submit eviCore managed Radiation/Oncology service requests to:
EviCore Healthcare Web: https://www.evicore.com/pages/providerlogin.aspx or
Phone: 1-888-693-3211 Fax: 1-866-699-8160.

Brachytherapy Stereotactic Radiation Therapy Intensity Modulated Radiation Therapy (IMRT) Neutron Beam Radiation Therapy Intraoperative Radiation Therapy (IORT) Proton Beam Radiation Therapy Hyperthermia Treatment Radiation Treatment Delivery Radiologic Guidance Therapeutic Radiopharmaceuticals

Criteria links:

Medical Policies
- Medical Policies provide guidelines for determining coverage for specific procedures, therapies, devices, equipment and services.

MCG Guidelines
- MCG provides guidelines for determining coverage for inpatient care as well as specific procedures, devices, equipment and services.

Codes listed under Vendor managed/ delegated services are included on the list.

Depending on the vendor listed, additional information related to criteria can be found per the corresponding delegated/vendor below.

Cohere

- Go here for information on Review Criteria.

Evicore

- Go here for information on Review Criteria.

Medicare Advantage Prior Authorization Medical Mutual acts in accordance with guidance and policies from the Centers for Medicare & Medicaid Services (CMS). Medicare coverage is limited to clinically proven items and services that are reasonable and necessary for the diagnosis or treatment of an illness or injury, and within the scope of a Medicare benefit category. CMS National Coverage Determinations (NCDs) are nationwide determinations of whether Medicare will pay for an item or service. Medical Mutual follows NCDs in making prior authorization determinations and in the absence of, or in conjunction with an NCD when specified, Local Coverage Determinations (LCDs) are followed. LCDs are regional determinations implemented by Medicare Administrative Contractors (MACs).

Drugs under Medical are not included on this list. Refer to Medical Drug Management | Medical Mutual for information.

Codes	Code Description	Medical Mutual Commercial	Medical Mutual Commercial Criteria	Medicare Advantage	Medicare Advantage Criteria	Details/Notes
00170	ANESTHESIA FOR INTRAORAL PROCEDURES, INCLUDING BIOPSY; NOT OTHERWISE SPECIFIED	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY (See Notes)	CMP202010	PRIOR AUTHORIZATION REQUIRED-FOLLOW MEDICARE COVERAGE CRITERIA (See Notes)	CMS	Prior authorization required for anesthesia for dental services only.
11920	TATTOOING, INTRADERMAL INTRODUCTION OF INSOLUBLE OPAQUE PIGMENTS TO CORRECT COLOR DEFECTS OF SKIN, INCLUDING MICROPIGMENTATION; 6.0 SQ CM OR LESS	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY (See Notes)	CMP94002	PRIOR AUTHORIZATION REQUIRED-FOLLOW MEDICARE COVERAGE CRITERIA (See Notes)	CMS	Prior authorization not required for personal history of breast cancer.
11921	TATTOOING, INTRADERMAL INTRODUCTION OF INSOLUBLE OPAQUE PIGMENTS TO CORRECT COLOR DEFECTS OF SKIN, INCLUDING MICROPIGMENTAITON; 6.1 TO 20.0 SQ CM	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY (See Notes)	CMP94002	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA (See Notes)	CMS	Prior authorization not required for personal history of breast cancer.
11922	TATTOOING, INTRADERMAL INTRODUCTION OF INSOLUBLE OPAQUE PIGMENTS TO CORRECT COLOR DEFECTS OF SKIN, INCLUDING MICROPIGMENTATION; EACH ADDITIONAL 20.0 SQ CM, OR PART THEREOF (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY (See Notes)	CMP94002	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA (See Notes)	CMS	Prior authorization not required for personal history of breast cancer.
11950	SUBCUTANEOUS INJECTION OF FILLING MATERIAL (EG, COLLAGEN); 1 CC OR LESS	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201929	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
11951	SUBCUTANEOUS INJECTION OF FILLING MATERIAL (EG, COLLAGEN); 1.1 TO 5.0 CC	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201929	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
11952	SUBCUTANEOUS INJECTION OF FILLING MATERIAL (EG, COLLAGEN); 5.1 TO 10.0 CC	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201929	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
11954	SUBCUTANEOUS INJECTION OF FILLING MATERIAL (EG, COLLAGEN); OVER 10.0 CC	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201929	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
11960	NSERTION OF TISSUE EXPANDER(S) FOR OTHER THAN BREAST, INCLUDING SUBSEQUENT EXPANSION	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201929	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
11970	REPLACEMENT OF TISSUE EXPANDER WITH PERMANENT IMPLANT	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY (See Notes)	CMP94002	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA (See Notes)	CMS	Prior authorization not required for personal history of breast cancer.
11971	REMOVAL OF TISSUE EXPANDER WITHOUT INSERTION OF IMPLANT	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY (See Notes)	CMP94002	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA (See Notes)	CMS	Prior authorization not required for personal history of breast cancer.
15769	GRAFTING OF AUTOLOGOUS SOFT TISSUE, OTHER, HARVESTED BY DIRECT EXCISION (EG, FAT, DERMIS, FASCIA)	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY (See Notes)	CMP94002	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA (See Notes)	CMS	Prior authorization not required for personal history of breast cancer.
15770	GRAFT; DERMA-FAT-FASCIA	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201929	PRIOR AUTHORIZATION REQUIRED-FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
15771	GRAFTING OF AUTOLOGOUS FAT HARVESTED BY LIPOSUCTION TECHNIQUE TO TRUNK, BREASTS, SCALP, ARMS, AND/OR LEGS; 50 CC OR LESS INJECTATE	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY (See Notes)	CMP94002	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA (See Notes)	CMS	Prior authorization not required for personal history of breast cancer.
15772	GRAFTING OF AUTOLOGOUS FAT HARVESTED BY LIPOSUCTION TECHNIQUE TO TRUNK, BREASTS, SCALP, ARMS, AND/OR LEGS; EACH ADDITIONAL 50 CC INJECTATE, OR PART THEREOF (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201929	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
15775	PUNCH GRAFT FOR HAIR TRANSPLANT; 1 TO 15 PUNCH GRAFTS	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201929	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
15776	PUNCH GRAFT FOR HAIR TRANSPLANT; MORE THAN 15 PUNCH GRAFTS	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201929	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
15780	DERMABRASION; TOTAL FACE (EG, FOR ACNE SCARRING, FINE WRINKLING, RHYTIDS, GENERAL KERATOSIS)	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201929	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	

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15781	DERMABRASION; SEGMENTAL, FACE	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201929	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
15783	DERMABRASION; SUPERFICIAL, ANY SITE (EG, TATTOO REMOVAL)	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201929	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
15786	ABRASION; SINGLE LESION (EG, KERATOSIS, SCAR)	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201929	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
15787	ABRASION; EACH ADDITIONAL FOUR LESIONS OR LESS (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201929	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
15788	CHEMICAL PEEL, FACIAL; EPIDERMAL	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201929	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
15789	CHEMICAL PEEL, FACIAL; DERMAL	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201929	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
15792	CHEMICAL PEEL, NONFACIAL; EPIDERMAL	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201929	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
15793	CHEMICAL PEEL, NONFACIAL; DERMAL	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201929	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
15820	BLEPHAROPLASTY, LOWER EYELID	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP96018	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
15821	BLEPHAROPLASTY, LOWER EYELIDS; WITH EXTENSIVE HERNIATED FAT PADS	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP96018	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
15822	BLEPHAROPLASTY, UPPER EYELID;	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP96018	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
15823	BLEPHAROPLASTY, UPPER EYELID; WITH EXCESSIVE SKIN WEIGHTING DOWN LID	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP96018	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
15824	RHYTIDECTOMY; FOREHEAD	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201929 MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
15826	RHYTIDECTOMY; GLABELLAR FROWN LINES	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201929, MCG A-0578 (CMP202406)	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
15828	RHYTIDECTOMY; CHEEK, CHIN, AND NECK	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201929	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
15829	RHYTIDECTOMY; SUPERFICIAL MUSCULOAPONEUROTIC SYSTEM (SMAS) FLAP	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201929	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
15830	EXCISION, EXCESSIVE SKIN AND SUBCUTANEOUS TISSUE (INCLUDES LIPECTOMY); ABDOMEN, INFRAUMBILICAL PANNICULECTOMY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
15832	EXCISION, EXCESSIVE SKIN AND SUBCUTANEOUS TISSUE (INCLUDING LIPECTOMY); THIGH	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201929	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
15833	EXCISION, EXCESSIVE SKIN AND SUBCUTANEOUS TISSUE (INCLUDING LIPECTOMY); LEG	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201929	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
15834	EXCISION, EXCESSIVE SKIN AND SUBCUTANEOUS TISSUE (INCLUDING LIPECTOMY); HIPS	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201929	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
15835	EXCISION, EXCESSIVE SKIN AND SUBCUTANEOUS TISSUE (INCLUDING LIPECTOMY); BUTTOCKS	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201929	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
15836	EXCISION, EXCESSIVE SKIN AND SUBCUTANEOUS TISSUE (INCLUDING LIPECTOMY); ARMS	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201929	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
15837	EXCISION, EXCESSIVE SKIN AND SUBCUTANEOUS TISSUE (INCLUDING LIPECTOMY); FOREARM OR HAND	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201929	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
15838	EXCISION, EXCESSIVE SKIN AND SUBCUTANEOUS TISSUE (INDLUDING LIPECTOMY); SUBMENTAL FAT PAD	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201929	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
15839	EXCISION, EXCESSIVE SKIN AND SUBCUTANEOUS TISSUE (INCLUDING LIPECTOMY); OTHER AREA	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201929	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
15847	EXCISION, EXCESSIVE SKIN AND SUBCUTANEOUS TISSUE (INCLUDES LIPECTOMY), ABDOMEN (EG, ABDOMINOPLASTY)(INCLUDES UMBILICAL TRANSPOSITION AND FASCIAL PLICATION) (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201929	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
15876	SUCTION ASSISTED LIPECTOMY; HEAD AND NECK	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201929	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
15877	SUCTION ASSISTED LIPECTOMY; TRUNK	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP202103, CMP201929	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
15878	SUCTION ASSISTED LIPECTOMY; UPPER EXTREMITY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP202103, CMP201929	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	

Codes	Code Description	Medical Mutual Commercial	Medical Mutual Commercial Criteria	Medicare Advantage	Medicare Advantage Criteria	Details/Notes
15879	SUCTION ASSISTED LIPECTOMY; LOWER EXTREMITY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP202103, CMP201929	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
17106	DESTRUCTION OF CUTANEOUS VASCULAR PROLIFERATIVE LESIONS (EG, LASER TECHNIQUE); LESS THAN 10 SQ CM	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY (See Notes)	CMP200501	PRIOR AUTHORIZATION **NOT** REQUIRED		Please refer to the Corporate Medical Policy to determine if condition requires prior authorization. Prior authorization not required for Medicare Advantage plans.
17107	DESTRUCTION OF CUTANEOUS VASCULAR PROLIFERATIVE LESIONS (EG, LASER TECHNIQUE); 10.0 / 50 SQ CM	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY (See Notes)	CMP200501	PRIOR AUTHORIZATION **NOT** REQUIRED		Please refer to the Corporate Medical Policy to determine if condition requires prior authorization. Prior authorization not required for Medicare Advantage plans.
17108	DESTRUCTION OF CUTANEOUS VASCULAR PROLIFERATIVE LESIONS (EG, LASER TECHNIQUE); OVER 50 SQ CM	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY (See Notes)	CMP200501	PRIOR AUTHORIZATION **NOT** REQUIRED		Please refer to the Corporate Medical Policy to determine if condition requires prior authorization. Prior authorization not required for Medicare Advantage plans.
17380	EXCISION, EXCESSIVE SKIN AND SUBCUTANEOUS TISSUE (INCLUDES LIPECTOMY); ABDOMEN, INFRAUMBILICAL PANNICULECTOMY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201609	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
17999	UNLISTED PROCEDURE, SKIN, MUCOUS MEMBRANE AND SUBCUTANEOUS TISSUE	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201609, CMP202405	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP	
19300	MASTECTOMY FOR GYNECOMASTIA	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
19303	MASTECTOMY, SIMPLE, COMPLETE	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY (See Notes)	CMP201609 MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA (See Notes)	CMS	Prior authorization not required for personal history of breast cancer.
19316	MASTOPEXY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY (See Notes)	CMP94002	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA (See Notes)	CMS	Prior authorization not required for personal history of breast cancer.
19318	BREAST REDUCTION	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
19325	BREAST AUGMENTATION WITH IMPLANT	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP94002, CMP201609	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
19328	REMOVAL OF INTACT BREAST IMPLANT	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY (See Notes)	CMP94002	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA (See Notes)	CMS	
19330	REMOVAL OF RUPTURED BREAST IMPLANT, INCLUDING IMPLANT CONTENTS (EG, SALINE, SILICONE GEL)	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY (See Notes)	CMP94002	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA (See Notes)	CMS	Prior authorization not required for personal history of breast cancer.
19340	INSERTION OF BREAST IMPLANT ON SAME DAY OF MASTECTOMY (IE, IMMEDIATE)	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY (See Notes)	CMP94002, CMP201609	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA (See Notes)	CMS	Prior authorization not required for personal history of breast cancer.
19342	INSERTION OR REPLACEMENT OF BREAST IMPLANT ON SEPARATE DAY FROM MASTECTOMY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY (See Notes)	CMP94002, CMP201609	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA (See Notes)	CMS	Prior authorization not required for personal history of breast cancer.
19350	NIPPLE/AREOLA RECONSTRUCTION	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY (See Notes)	CMP94002, CMP201609	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA (See Notes)	CMS	Prior authorization not required for personal history of breast cancer.
19357	TISSUE EXPANDER PLACEMENT IN BREAST RECONSTRUCTION, INCLUDING SUBSEQUENT EXPANSION(S)	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY (See Notes)	CMP94002	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA (See Notes)	CMS	Prior authorization not required for personal history of breast cancer.
19361	BREAST RECONSTRUCTION; WITH LATISSIMUS DORSI FLAP	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY (See Notes)	CMP94002	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA (See Notes)	CMS	Prior authorization not required for personal history of breast cancer.
19364	BREAST RECONSTRUCTION; WITH FREE FLAP (EG, fTRAM, DIEP, SIEA, GAP FLAP)	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY (See Notes)	CMP94002	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA (See Notes)	CMS	Prior authorization not required for personal history of breast cancer.
19367	BREAST RECONSTRUCTION; WITH SINGLE-PEDICLED TRANSVERSE RECTUS ABDOMINIS MYOCUTANEOUS (TRAM) FLAP	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY (See Notes)	CMP94002	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA (See Notes)	CMS	Prior authorization not required for personal history of breast cancer.
19368	BREAST RECONSTRUCTION; WITH SINGLE-PEDICLED TRANSVERSE RECTUS ABDOMINIS MYOCUTANEOUS (TRAM) FLAP, REQUIRING SEPARATE MICROVASCULAR ANASTOMOSIS (SUPERCHARGING)	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY (See Notes)	CMP94002	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA (See Notes)	CMS	Prior authorization not required for personal history of breast cancer.
19369	BREAST RECONSTUCTION; WITH BIPEDICLED TRANSVERSE RECTUS ABDOMINIS MYOCUTANEOUS (TRAM) FLAP	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY (See Notes)	CMP94002	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA (See Notes)	CMS	Prior authorization not required for personal history of breast cancer.
19370	REVISION OF PERI-IMPLANT CAPSULE, BREAST, INCLUDING CAPSULOTOMY, CAPSULORRHAPHY, AND/OR PARTIAL CAPSULECTOMY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY (See Notes)	CMP94002	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA (See Notes)	CMS	Prior authorization not required for personal history of breast cancer.
19371	PERI-IMPLANT CAPSULECTOMY, BREAST, COMPLETE, INCLUDING REMOVAL OF ALL INTRACAPSULAR CONTENTS	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY (See Notes)	CMP94002	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA (See Notes)	CMS	Prior authorization not required for personal history of breast cancer.
19380	REVISION OF RECONSTRUCTED BREAST (EG, SIGNIFICANT REMOVAL OF TISSUE, RE-ADVANCEMENT AND/OR RE-INSET OF FLAPS IN AUTOLOGOUS RECONSTRUCTION OR SIGNIFICANT CAPSULAR REVISION COMBINED WITH SOFT TISSUE EXCISION IN IMPLANT-BASED RECONSTRUCTION)	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY (See Notes)	CMP94002	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA (See Notes)	CMS	Prior authorization not required for personal history of breast cancer.
19396	PREPARATION OF MOULAGE FOR CUSTOM BREAST IMPLANT	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY (See Notes)	CMP94002	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA (See Notes)	CMS	Prior authorization not required for personal history of breast cancer.

Codes	Code Description	Medical Mutual Commercial	Medical Mutual Commercial Criteria	Medicare Advantage	Medicare Advantage Criteria	Details/Notes
19499	UNLISTED PROCEDURE; BREAST	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY (See Notes)	CMP94002, CMP200211, CMP202405	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP	Prior authorization not required for personal history of breast cancer.
20912	CARTILAGE GRAFT; NASAL SEPTUM	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	CMP 201929	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
20930	ALLOGRAFT, MORSELIZED, OR PLACEMENT OF OSTEOPROMOTIVE MATERIAL, FOR SPINE SURGERY ONLY (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY (See Notes)	CMP200403	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY-SEE NOTES	CMP	Prior authorization required for Recombinant bone morphogenic proteins
20931	ALLOGRAFT, STRUCTURAL, FOR SPINE SURGERY ONLY (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY (See Notes)	CMP200403	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY-SEE NOTES	CMP	Prior authorization required for Recombinant bone morphogenic proteins
20974	ELECTRICAL STIMULATION TO AID BONE HEALING; NONINVASIVE (NON OPERATIVE)	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
20975	ELECTRICAL STIMULATION TO AID BONE HEALING; INVASIVE (OPERATIVE)	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
20979	LOW INTENSITY ULTRASOUND STIMULATION TO AID BONE HEALING, NONINVASIVE (NONOPERATIVE)	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
20982	ABLATION THERAPY FOR REDUCTION OR ERADICATION OF 1 OR MORE BONE METASTASIS INCLUDING ADJACENT SOFT TISSUE WHEN INVOLVED BY TUMOR EXTENSION, PERCUTANEOUS INCLUDING IMAGING GUIDANCE WHEN PERFORMED; RADIOFREQUENCY	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES (See Notes)	MCG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
20983	ABLATION THERAPY FOR REDUCTION OR ERADICATION OF 1 OR MORE BONE TUMORS (EG,METASTASIS) INCLUDING ADJACENT SOFT TISSUE WHEN INVOLVED BY TUMOR EXTENSION, PERCUTANEOUS, INCLUDING IMAGING GUIDANCE WHEN PERFORMED;CRYOBLATION	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP200802	PRIOR AUTHORIZATION NOT REQUIRED		
20999	UNLISTED PROCEDURE, MUSCULOSKELETAL SYSTEM, GENERAL	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP2006-D	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
21010	ARTHROTOMY, TEMPOROMANDIBULAR JOINT	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
21087	IMPRESSION AND CUSTOM PREP; NASAL PROSTHESIS	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP200509	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP	
21120	GENIOPLASTY; AUGMENTATION (AUTOGRAFT, ALLOGRAFT, PROSTHETIC MATERIAL)	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201929	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
21121	GENIOPLASTY; SLIDING OSTEOTOMY, SINGLE PIECE	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201929	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
21122	GENIOPLASTY; SLIDING OSTEOTOMIES, TWO OR MORE OSTEOTOMIES (EG, WEDGE EXCISION OR BONE WEDGE REVERSAL FOR ASYMMETRICAL CHIN)	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201929	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
21123	GENIOPLASTY; SLIDING, AUGMENTATION WITH INTERPOSITIONAL BONE GRAFTS (INCLUDES OBTAINING GRAFTS)	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201929	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
21125	AUGMENTATION, MANDIBULAR BODY OR ANGLE; PROSTHETIC MATERIAL	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201929	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
21127	AUGMENTATION, MANDIBULAR BODY OR ANGLE; WITH BONE GRAFT, ONLAY OR INTERPOSITIONAL (INCLUDES OBTAINING AUTOGRAFT)	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201929	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
21137	REDUCTION FOREHEAD; CONTOURING ONLY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201929	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
21138	REDUCTION FOREHEAD; CONTOURING AND APPLICATION OF PROSTHETIC MATERIAL OR BONE GRAFT (INCLUDES OBTAINING AUTOGRAFT)	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201929	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
21139	REDUCTION FOREHEAD; CONTOURING AND SETBACK OF ANTERIOR FRONTAL SINUS WALL	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201929	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
21141	RECONSTRUCT MIDFACE, LEFORT 1, SINGLE PIECE, W/O BONE GRAFT	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
21142	RECONST. MIDFACE, LEFORT1; TWO PIECES	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
21143	RECONST MIDFACE, LEFORT 1; THREE OR MORE PIECES	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
21145	RECONSTRUCT MIDFACE, LEFORT 1, SINGLE PIECE, W/ BONE GRAFT	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
21146	LEFORT I-2 PC INCL GRAFTS	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
21147	LEFORT I-3+PCS INCL GRAFTS - BILATERAL	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
21154	RECONSTRUCTION MIDFACE, LEFORT III (EXTRACRANIAL), ANY TYPE, REQUIRING BONE GRAFTS (INCLUDES OBTAINING AUTOGRAFTS); WITHOUT LEFORT I	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	

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21155	RECONSTRUCTION MIDFACE, LEFORT III (EXTRACRANIAL), ANY TYPE, REQUIRING BONE GRAFTS (INCLUDES OBTAINING AUTOGRAFTS); WITH LEFORT I	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
21159	RECONSTRUCTION MIDFACE, LEFORT III (EXTRA AND INTRACRANIAL) WITH FOREHEAD ADVANCEMENT (EG, MONO BLOC), REQUIRING BONE GRAFTS (INCLUDES OBTAINING AUTOGRAFTS); WITHOUT LEFORT I	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
21160	RECONSTRUCTION MIDFACE, LEFORT III (EXTRA AND INTRACRANIAL) WITH FOREHEAD ADVANCEMENT (EG, MONO BLOC), REQUIRING BONE GRAFTS (INCLUDES OBTAINING AUTOGRAFTS); WITH LEFORT I	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
21172	RECONSTRUCTION SUPERIOR\LATERAL ORBITAL RIM AND LOWER FOREHEAD, ADVANCEMENT OR ALTERATION, WITH OR WITHOUT GRAFTS (INCLUDES OBTAINING AUTOGRAFTS)	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
21175	RECONSTRUCTION, BIFRONTAL, SUPERIOR\LATERAL ORBITAL RIMS AND LOWER FOREHEAD, ADVANCEMENT OR ALTERATION (EG, PLAGIOCEPHALY, TRIGONOCEPHALY, BRACHYCEPHALY), WITH OR WITHOUT GRAFTS (INCLUDES OBTAINING AUTOGRAFTS)	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
21179	RECONSTRUCTION, ENTIRE OR MAJORITY OF FOREHEAD AND/OR SUPRAORBITAL RIMS; WITH GRAFTS (ALLOGRAFT OR PROSTHETIC MATERIAL)	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
21180	RECONSTRUCTION, ENTIRE OR MAJORITY OF FOREHEAD AND/OR SUPRAORBITAL RIMS; WITH AUTOGRAFT (INCLUDES OBTAINING GRAFTS)	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
21182	RECONSTRUCTION OF ORBITAL WALLS, RIMS, FOREHEAD, NASOETHMOID COMPLEX FOLLOWING INTRA AND EXTRACRANIAL EXCISION OF BENIGN TUMOR OF CRANIAL BONE (EG, FIBROUS DYSPLASIA), WITH MULTIPLE AUTOGRAFTS (INCLUDES OBTAINING GRAFTS); TOTAL AREA OF BONE GRAFTING LESS THAN 40 SQ CM	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
21183	RECONSTRUCTION OF ORBITAL WALLS, RIMS, FOREHEAD, NASOETHMOID COMPLEX FOLLOWING INTRA AND EXTRACRANIAL EXCISION OF BENIGN TUMOR OF CRANIAL BONE (EG, FIBROUS DYSPLASIA), WITH MULTIPLE AUTOGRAFTS (INCLUDES OBTAINING GRAFTS); TOTAL AREA OF BONE GRAFTING GREATER THAN 40 SQ CM BUT LESS THAN 80 SQ CM	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
21184	RECONSTRUCTION OF ORBITAL WALLS, RIMS, FOREHEAD, NASOETHMOID COMPLEX FOLLOWING INTRA AND EXTRACRANIAL EXCISION OF BENIGN TUMOR OF CRANIAL BONE (EG, FIBROUS DYSPLASIA), WITH MULTIPLE AUTOGRAFTS (INCLUDES OBTAINING GRAFTS); TOTAL AREA OF BONE GRAFTING GREATER THAN 80 SQ CM	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
21188	RECONSTRUCTION MIDFACE, OSTEOTOMIES (OTHER THAN LEFORT TYPE) AND BONE GRAFTS (INCLUDES OBTAINING AUTOGRAFTS)	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
21195	RECONSTRUCT MANDIBULAR RAMI; W/O INTERNAL RIGID FIXATION	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP202401	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
21196	RECONSTRUCT MANDIBULAR RAMI; W/INTERNAL RIGID FIXATION	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
21199	OSTEOTOMY MANDIBLE SGMTL W/GENIOGLOSSUS ADVMNT	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED-FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
21209	OSTEOPLASTY, FACIAL BONES; REDUCTION	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED-FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
21210	GRAFT, BONE; NASAL, MAXILLARY AND MALAR AREAS (INCLUDES OBTAINING GRAFT)	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
21215	GRAFT, BONE; MANDIBLE	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED-FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
21230	GRAFT; RIB CARTILAGE, AUTOGENOUS, TO FACE CHIN, NOSE OR EAR (INCLUDES OBTAINING GRAFT)	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	CMP 201929	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
21235	GRAFT; EAR CARTILAGE, AUTOGRAFT, TO NOSE OR EAR (INCLUDES OBTAINING GRAFT)	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP 201929	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
21240	ARTHRP TEMPOROMANDIBULAR JOINT W/WO AUTOGRAFT	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED-FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
21243	ARTHRP TMPRMAND JOINT W/PROSTHETIC REPLACEMENT	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED-FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
21244	RECONSTRUCT OF MANDIBLE EXTRAORAL, W/ BONE PLATE	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP202401	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
21245	RECONST MANDIBLE/MAXILLA, SUBPERIOSTEAL IMPLANT, PARTIAL	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP202401	PRIOR AUTHORIZATION REQUIRED-FOLLOW MEDICARE COVERAGE CRITERIA	CMS	

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21248	RECONSTRUCT MANDIBLE/MAXILLA, ENDOSTEAL IMPLANT	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED-FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
21256	RECONSTRUCTION OF ORBIT WITH OSTEOTOMIES (EXTRACRANIAL) AND WITH BONE GRAFTS (INCLUDES OBTAINING AUTOGRAFTS) (EG, MICRO\OPHTHALMIA)	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
21270	MALAR AUGMENTATION, PROSTHETIC MATERIAL	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201929	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
21280	MEDIAL CANTHOPEXY (SEPARATE PROCEDURE)	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
21282	LATERAL CANTHOPEXY	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
21295	REDUCTION OF MASSETER MUSCLE AND BONE (EG, FOR TREATMENT OF BENIGN MASSETERIC HYPERTROPHY); EXTRAORAL APPROACH	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201929	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
21296	REDUCTION OF MASSETER MUSCLE AND BONE (EG, FOR TREATMENT OF BENIGN MASSETERIC HYPERTROPHY); INTRAORAL APPROACH	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201929	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
21299	UNLISTED CRANIOFACIAL AND MAXILLOFACIAL PROCEDURE	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG A-0578 (CMP202406)	PRIOR AUTHORIZATION REQUIRED-FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
21740	RECONSTRUCTIVE REPAIR OF PECTUS EXCAVATUM OR CARINATUM; OPEN	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP200905	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP	
21742	RECONSTRUCTIVE REPAIR OF PECTUS EXCAVATUM OR CARINATUM; MINIMALLY INVASIVE APPROACH (NUSS PROCEDURE), WITHOUT THORACOSCOPY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP200905	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP	
21743	RECONSTRUCTIVE REPAIR OF PECTUS EXCAVATUM OR CARINATUM; MINIMMALLY INVASIVE APPROACH (NUSS PROCEDURE), WITH THORACOSCOPY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP200905	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP	
21899	UNLISTED PROCEDURE, NECK OR THORAX	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP202405	PRIOR AUTHORIZATION REQUIRED-FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
22100	PARTIAL EXCISION OF POSTERIOR VERTEBRAL COMPONENT; CERVICAL	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
22110	PARTIAL EXCISION OF VERTEBRAL BODY; CERVICAL	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
22214	OSTEOTOMY SPINE, POSTERIOR APPROACH, ONE VERT SEGMENT; LUMBAR	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
22224	OSTEOTOMY SPINE ANTERIOR APPROACH; LUMBAR	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
22510	PERC VERTEBROPLSTY, 1 VERTBRL BODY, UNI/BI INJ, INCL IMAG GUIDE; CERVICOTHORACIC	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
22511	PERCUTANEOUS VERTEBROPLASTY, ONE VERTEBRAL BODY; LUMBOSACRAL	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
22512	PERC VRTBRPLSTY, 1 VERTBRL BODY, UNI/BI INJ, W/ IMAG GUIDE; EA ADDTL VERTBL BODY	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
22513	PERC VRTBRL AUGMNTATION, 1 VRTBRL BODY, UNI/BI CANNULATION, INCL IMAGE; THORACIC	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
22514	PERC VRTBRL AUGMNTATION, 1 VRTBRL BODY, UNI/BI CANNULATION, INCL IMAGE; LUMBAR	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
22515	PERC VRTBRL AUGMNTATION, 1 VRTBRL BODY, UNI/BI CANNULATION, INCL IMAGE; EA ADDTL	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
22533	ARTHRODESIS, LATERAL EXTRACAVITARY TECHNIQUE, INCLUDING MINIMAL DISKECTOMY TO PREPARE INTERSPACE (OTHER THAN FOR DECOMPRESSION); LUMBAR	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
22534	ARTHRODESIS, LATERAL EXTRACAVITARY TECHNIQUE, INCLUDING MINIMAL DISKECTOMY TO PREPARE INTERSPACE (OTHER THAN FOR DECOMPRESSION); THORACIC OR LUMBAR, EACH ADDITIONAL VERTEBRAL SEGMENT (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
22551	ARTHRODESIS, ANTERIOR INTERBODY INCLD DISC SPACE PREP; CERVICAL BELOW C2	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
22552	ARTHRODESIS, ANTERIOR INTERBODY INCLD DISC SPACE ; BELOW C2 EA ADDTL INTERSPACE	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
22554	ARTHRODESIS, ANT INTERBODY TECHNIQUE; CERVICAL	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
22558	ARTHRODESIS, ANTERIOR INTERBODY TECHNIQUE, INCLUDING MINIMAL DISKECTOMY TO PREPARE INTERSPACE (OTHER THAN FOR DECOMPRESSION); LUMBAR	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	

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22585	ARTHRODESIS, ANT INTERBODY TECHNIQUE; EA ADDL INTERSPACE	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
22610	ARTHRODESIS, POSTERIOR/POSTEROLATERAL, SINGLE LEVEL; THORACIC	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
22612	ARTHRODESIS, POSTERIOR OR POSTEROLATERAL TECHNIQUE, SINGLE LEVEL; LUMBAR (WITH LATERAL TRANSVERSE TECHNIQUE, WHEN PERFORMED)	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
22614	ARTHRODESIS, POSTERIOR/ POSTEROLATERAL, SINGLE LEVEL; EA ADDL SEG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
22630	ARTHRODESIS, POSTERIOR INTERBODY TECHNIQUE, INCLUDING LAMINECTOMY AND/OR DISKECTOMY TO PREPARE INTERSPACE (OTHER THAN FOR DECOMPRESSION), SINGLE INTERSPACE; LUMBAR	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
22632	ARTHRODESIS, POSTERIOR INTERBODY TECHNIQUE, INCLUDING LAMINECTOMY AND/OR DISKECTOMY TO PREPARE INTERSPACE (OTHER THAN FOR DECOMPRESSION), SINGLE INTERSPACE; EACH ADDITIONAL INTERSPACE (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
22633	ARTHRODESIS, COMBINED POSTERIOR OR POSTEROLATERAL TECHNIQUE WITH POSTERIOR INTERBODY TECHNIQUE INCLUDING LAMINECTOMY AND/OR DISECTOMY SUFFICIENT TO PREPARE INTERSPACE (OTHER THAN FOR DECOMPRESSION), SINGLE INTERSPACE AND SEGMENT; LUMBAR	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
22634	ARTHRODESIS, COMBINED POSTERIOR OR POSTEROLATERAL TECHNIQUE WITH POSTERIOR INTERBODY TECHNIQUE INCLUDING LAMINECTOMY AND/OR DISCECTOMY SUFFICIENT TO PREPARE INTERSPACE (OTHER THAN FOR DECOMPRESSION), SINGLE INTERSPACE AND SEGMENT; EACH ADDITIONAL INTERSPACE AND SEGMENT (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
22800	ARTHRODESIS, POSTERIOR, FOR SPINAL DEFORMITY, WITH OR WITHOUT CAST; UP TO 6 VERTEBRAL SEGMENTS	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
22802	ARTHRODESIS, POSTERIOR, FOR SPINAL DEFORMITY; 7 - 12 VERT SEGMENTS	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
22804	ARTHRODESIS, POSTERIOR, 13 OR MORE VERTEBRAL SEGMENTS	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
22808	ARTHRODESIS, ANTERIOR, FOR SPINAL DEFORMITY, WITH OR WITHOUT CAST; 2 TO 3 VERTEBRAL SEGMENTS	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
22830	EXPLORATION SPINAL FUSION	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
22836	ANTERIOR THORACIC VERTEBRAL BODY TETHERING, INCLUDING THORACOSCOPY, WHEN PERFORMED; UP TO 7 VERTEBRAL SEGMENTS	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP202013	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP	
22837	ANTERIOR THORACIC VERTEBRAL BODY TETHERING, INCLUDING THORACOSCOPY, WHEN PERFORMED; 8 OR MORE VERTEBRAL SEGMENTS	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP202013	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP	
22838	REVISION (EG, AUGMENTATION, DIVISION OF TETHER), REPLACEMENT, OR REMOVAL OF THORACIC VERTEBRAL BODY TETHERING, INCLUDING THORACOSCOPY, WHEN PERFORMED	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP202013	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP	
22840	POSTERIOR NON-SEGMENTAL INSTRUMENTATION	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
22842	POSTERIOR SEGMENTAL INSTRUMENTATION; 3 - 6 VERT SEGMENTS	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
22843	POSTERIOR SEGMENTAL INSTRUMENTATION 7-12 VRT SEG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
22844	POSTERIOR SEG INSTRUMNTATN; 13 OR MORE VERTEBRAL SEGMENTS	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
22845	ANTERIOR INSTRUMENTATION; 2 - 3 VERT SEGMENTS	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
22846	ANTERIOR INSTRUMENTATION; 4 - 7 VERT SEGMENTS	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
22849	REINSERTION SPINAL FIXATION DEVICE	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
22850	REMOVAL OF POSTERIOR NONSEGMENTAL INSTRUMENTATION	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
22852	REMOVE POSTERIOR SEGMENTAL INSTRUMENTATION	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
22853	INSERT INTERBODY BIOMECH DEVICE(S) W/INTEGRAL ANTERIOR INSTR FOR ANCHORING, EA	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	

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22855	REMOVAL ANTERIOR INSTRUMENTATION	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
22856	TOTAL DISC ARTHROPLASTY (ARTIFICIAL DISC), ANTERIOR APPROACH, INCLUDING DISCECTOMY WITH END PLATE PREPARATION (INCLUDES OSTEOPHYTECTOMY FOR NERVE ROOT OR SPINAL CORD DECOMPRESSION AND MICRODISSECTION); SINGLE INTERSPACE, CERVICAL	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP200813	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
22857	TOTAL DISC ARTHROPLASTY (ARTIFICIAL DISC), ANTERIOR APPROACH, INCLUDING DISCECTOMY TO PREPARE INTERSPACE (OTHER THAN FOR DECOMPRESSION, SINGLE INTERSPACE, LUMBAR	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP200813	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
22858	TOTAL DISC ARTHROPLASTY (ARTIFICIAL DISC), ANTERIOR APPROACH, INCLUDING DISCECTOMY WITH ENDPLATE PREPARATION (INCLUDES OSTEOPHYTECTOMY FOR NERVE ROOT OR SPINAL CORD DECOMPRESSION AND MICRODISSECTION); SECOND LEVEL, CERVICAL (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP200813	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
22860	TOTAL DISC ARTHROPLASTY (ARTIFICIAL DISC), ANTERIOR APPROACH, INCLUDING DISCECTOMY TO PREPARE INTERSPACE (OTHER THAN FOR DECOMPRESSION); SECOND INTERSPACE, LUMBAR	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP200813	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
22861	REVISION INCLUDING REPLACEMENT OF TOTAL DISC ARTHROPLASTY (ARTIFICIAL DISC), ANTERIOR DISC), ANTERIOR APPROACH, SINGLE INTERSPACE; CERVICAL	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP200813	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
22862	REVISION INCLUDING REPLACEMENT OF TOTAL DISC ARTHROPLASTY (ARTIFICIAL DISC) ANTERIOR APPROACH, SINGLE INTERSPACE; LUMBAR	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP200813	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
22867	INSERTION OF INTERLAMINAR/INTERSPINOUS PROCESS STABILIZATION/DISTRACTION DEVICE, WITHOUT FUSION, INCLUDING IMAGE GUIDANCE WHEN PERFORMED, WITH OPEN DECOMPRESSION, LUMBAR; SINGLE LEVEL	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES (See Notes)	MCG A-0494 (CMP202406)	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
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 REQUIRED - MILLIMAN CARE GUIDELINES (See Notes)	MCG A-0494 (CMP202406)	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
22869	INSERTION OF INTERLAMINAR/INTERSPINOUS PROCESS STABILIZATION/DISTRACTION DEVICE, WITHOUT OPEN DECOMPRESSION OR FUSION, INCLUDING IMAGE GUIDANCE WHEN PERFORMED, LUMBAR; SINGLE LEVEL	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES (See Notes)	MCG A-0494 (CMP202406)	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
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 REQUIRED - MILLIMAN CARE GUIDELINES (See Notes)	MCG A-0494 (CMP202406)	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
22899	UNLISTED PROCEDURE, SPINE	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201537, CMP200813, CMP200403, CMP202013, CMP202405, MCG A-0217 (CMP202407)	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
22999	UNLISTED PROCEDURE, ABDOMEN, MUSCULOSKELETAL SYSTEM	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP202405	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
23470	ARTHROPLASTY, GLENOHUMERAL JOINT; HEMIARTHROPLASTY	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
23472	ARTHROPLASTY, GLENOHUMERAL JOINT; TOTAL SHOULDER REPLACEMENT	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
23929	UNLISTED PROCEDURE, SHOULDER	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP202405, CMP201527, CMP2006-D, CMP2013-C	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP	
24362	ARTHROPLASTY, ELBOW; W/ IMPLANT AND FASCIA LATA LIGAMENT	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
24363	ARTHROPLASTY, ELBOW; WITH PROSTHETIC REPLACEMENT	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
24999	UNLISTED PROCEDURE, HUMERUS OR ELBOW	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP2006-D, CMP2013-C, CMP201527, CMP202405	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP	
25999	UNLISTED PROCEDURE, FOREARM OR WRIST	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201527, CMP202405	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP	
26989	UNLISTED PROCEDURE; HANDS OR FINGERS	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201527, CMP202405	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP	

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27096	INJECT SI JOINT ARTHRGRPHY&/ANES/STEROID W/IMAGE	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP202402	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
27130	ARTHROPLASTY, ACETABULAR & PROXIMAL FEMORAL PROSTHETIC REPLACEMENT (TOTAL HIP)	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
27132	CONVERSION OF PREVIOUS HIP SURGERY TO TOTAL HIP ARTHROPLASTY	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
27134	REVISION OF TOTAL HIP ARTHROPLASTY; BOTH COMPONENTS	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
27137	REVISION OF TOTAL HIP ARTHROPLASTY; ACETABULAR COMPONENT ONLY	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
27138	REVISION OF TOTAL HIP ARTHROPLASTY; FEMORAL COMPONENT ONLY	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
27279	ARTHRODESIS, SACROILIAC JOINT, PERCUTANEOUS OR MINIMALLY INVASIVE (INDIRECT VISUALIZATION), WITH IMAGE GUIDANCE, INCLUDES OBTAINING BONE GRAFT WHEN PERFORMED, AND PLACEMENT OF TRANSFIXING DEVICE	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
27280	ARTHRODESIS, OPEN, SACROILIAC JOINT (INCLUDING BONE GRAFT)	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
27412	AUTOLOGOUS CHONDROCYTE IMPLANTATION, KNEE	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP200613	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP	
27415	OSTEOCHONDRAL ALLOGRAFT, KNEE, OPEN	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP200613	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP	
27416	OSTEOCHONDRAL AUTOGRAFT(S), KNEE, OPEN (EG, MOSAICPLASTY) (INCLUDES HARVESTING OF AUTOGRAFTS)	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP200613	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP	
27438	ARTHRPLSTY PATELLA; W/PROSTHES	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
27445	ARTHROPLASTY KNEE HINGE PROSTHESIS	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
27446	ARTHRP KNEE CONDYLE&PLATEAU MEDIAL/LAT CMPRT	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
27447	ARTHRP KNE CONDYLE&PLATU MEDIAL&LAT CMPRTS	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
27486	REVJ TOTAL KNEE ARTHRP W/WO ALGRFT 1 COMPONENT	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
27487	REVISION TOTAL KNEE ARTHROPLASTY; FEMORAL & ENTIRE TIBIAL COMPONENT	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
27599	UNLISTED PROCEDURE, FEMUR OR KNEE	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP2006-D, CMP2013-C, CMP202501, CMP201527, CMP202405, CMP202201	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP	
27703	ARTHROPLASTY ANKLE REVISION TOTAL ANKLE	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
27899	UNLISTED PROCEDURE, LEG AND ANKLE	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP2006-D, CMP2013-C, CMP201527, CMP202405, CMP200403	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP	
28291	HALLUX RIGIDUS CORRECT W/CHEILECTOMY, DEBRIDE & RELEASE 1ST MET JOINT; W/IMPLANT	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
28298	CORRECT HALLUX VALGUS W/SESAMOIDECTOMY; W/PROX PHALANX OSTEOTOMY, ANY METHOD	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
28299	CORRECT HALLUX VALGUS W/SESAMOIDECTOMY; W/DOUBLE OSTEOTOMY, ANY METHOD	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
28899	UNLISTED PROCEDURE, FOOT OR TOES	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP2013-C, CMP202405	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP	
29800	ARTHROSCOPY, TEMPOROMANDIBULAR JOINT, DIAGNOSTIC, W/WO BIOPSY	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
29804	ARTHROSCOPY TMJ SURGICAL	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED-FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
29806	ARTHROSCOPY, SHOULDER, SURG; CAPSULORRHAPHY	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
29807	ARTHROSCOPY, SHOULDER, SURG; REPAIR SLAP LESION	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
29819	ARTHROSCOPY SHOULDER SURGICAL REMOVAL LOOSE/FB	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	

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29820	ARTHROSCOPY, SHOULDER, SURG; SYNOVECTOMY, PARTIAL	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
29821	ARTHROSCOPY, SHOULDER, SURG; SYNOVECTOMY, COMPLETE	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
29822	ARTHROSCOPY, SHOULDER, SURG; DEBRIDEMENT, LIMITED	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
29823	ARTHROSCOPY, SHOULDER, SURG; DEBRIDEMENT, EXTENSIVE	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
29824	ARTHROSCOPY, SHOULDER, SURG; MUMFORD PROCEDURE	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
29825	ARTHROSCOPY, SHOULDER, SURG; W/LYSIS & RESECTION OF ADHESIONS, W OR W/O MANIP	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
29827	ARTHROSCOPY, SHOULDER, SURG; W/ROTATOR CUFF REPAIR	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	MCG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
29828	ARTHROSCOPY SHOULDER BICEPS TENODESIS	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
29834	ARTHROSCOPY, ELBOW, SURG; W/REMOVAL LOOSE/FOREIGN BODY	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
29835	ARTHROSCOPY, ELBOW, SURG; SYNOVECTOMY, PARTIAL	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
29837	ARTHRSCPY,ELBOW,SRGCL;DEBRIDEM	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
29838	ARTHROSCOPY, ELBOW, SURG; DEBRIDEMENT, EXTENSIVE	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
29844	ARTHROSCOPY, WRIST, SURG; SYNOVECTOMY, PARTIAL	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
29846	ARTHRS WRST EXC&/RPR TRIANG FIBROCART&/JT DBRDMT	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
29847	ARTHROSCOPY, WRIST, SURG; INT FIXATION FOR FX/INSTABILITY	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
29856	ARTHROSCOPICALLY AIDED TREATMENT OF TIBIAL FRACTURE, PROXIMAL (PLATEAU); BICONDYLAR, INCLUDES INTERNAL FIXATION, WHEN PERFORMED (INCLUDES ARTHROSCOPY)	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP2019-B	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP	
29860	ARTHROSCOPY, HIP, DIAGNOSTIC W/WO SYNOVIAL BIOPSY	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
29861	ARTHROSCOPY, HIP, SURG; W/REMOVAL LOOSE/FOREIGN BODY	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
29862	ARTHROSCOPY, HIP, SURG; W/DEBRIDEMENT/SHAVING OF ARTIC CARTILAGE	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
29863	ARTHROSCOPY, HIP, SURGICAL; W/ SYNOVECTOMY	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
29866	ARTHROSCOPY, KNEE, SURGICAL; OSTEOCHONDRAL AUTOGRAFT(S) (EG, MOSAICPLASTY)(INCLUDES HARVESTING OF THE AUTOGRAFT(S))	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP200613	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP	
29867	ARTHROSCOPY, KNEE, SURGICAL; OSTEOCHONDRAL ALLOGRAFT (EG, MOSAICPLASTY)	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP200613	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP	
29868	ARTHROSCOPY, KNEE, SURGICAL; MENISCAL TRANSPLANTATION (INCUDES ARTHROTOMY FOR MENISCAL INSERTION), MEDIAL OR LATERAL	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP200714	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP	
29871	ARTHROSCOPY, KNEE, SURG; FOR INFECTION, LAVAGE/DRAINAGE	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
29873	ARTHROSCOPY, KNEE, SURG; W/LATERAL RELEASE	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
29874	ARTHROSCOPY, KNEE, SURG; FOR REMOVAL LOOSE/FOREIGN BODY	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
29875	ARTHROSCOPY, KNEE, SURG; SYNOVECTOMY, LIMITED	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
29876	ARTHROSCOPY KNEE SYNOVECTOMY 2/>COMPARTMENTS	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
29877	ARTHRS KNEE DEBRIDEMENT/SHAVING ARTCLR CRTLG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
29879	ARTHRS KNEE ABRASION ARTHRP/MLT DRLG/MICROFX	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	

Codes	Code Description	Medical Mutual Commercial	Medical Mutual Commercial Criteria	Medicare Advantage	Medicare Advantage Criteria	Details/Notes
29880	ARTHRS KNEE W/MENISCECTOMY MED&LAT W/SHAVING	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
29881	ARTHRS KNE SURG W/MENISCECTOMY MED/LAT W/SHVG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
29882	ARTHROSCOPY, KNEE, SURG; W/MENISCUS REPAIR, MED OR LAT	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
29883	ARTHROSCOPY, KNEE, SURG; W/MENISCUS REPAIR (MEDIAL AND LATERAL)	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
29884	ARTHROSCOPY KNEE W/LYSIS ADHESIONS+-MNPJ SPX	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
29885	ARTHRS KNEE DRILL OSTEOCHONDRITIS DISSECANS GRFG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
29886	ARTHROSCOPY, KNEE, SURG; DRILLING FOR INTACT OSTEOCHONDRITIS DISSECANS LESION	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
29887	ARTHROSCOPY,KNEE,SURG; DRILL INTACT OSTEOCHONDRITIS DISSECANS LES W/INT FIXATION	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
29888	ARTHRS AIDED ANT CRUCIATE LIGM RPR/AGMNTJ/RCNSTJ	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
29889	ARTHRS AIDED PST CRUCIATE LIGM RPR/AGMNTJ/RCNSTJ	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
29891	ARTHRS ANKLE EXC OSTCHNDRL DFCT W/DRLG DFCT	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
29892	ARTHRS AID RPR LES/TALAR DOME FX/TIBL PLAFOND FX	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	MCG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
29894	ARTHROSCOPY, ANKLE, SURG; W/REM LOOSE/FOREIGN BODY	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
29895	ARTHROSCOPY, ANKLE, SURG; SYNOVECTOMY, PARTIAL	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
29897	ARTHROSCOPY, ANKLE, SURG; DEBRIDEMENT, LIMITED	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
29898	ARTHROSCOPY, ANKLE, SURG; DEBRIDEMENT, EXTENSIE	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
29899	SURG ANKLE ARTHROSCOPY W ANKLE ARTHRODESIS	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
29914	ARTHROSCOPY, HIP, SURGICAL; WITH FEMOROPLASTY	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
29915	ARTHROSCOPY, HIP, SURGICAL; WITH ACETABULOPLASTY	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
29916	ARTHROSCOPY, HIP, SURGICAL WITH LABRAL REPAIR	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
29999	UNLISTED PROCEDURE, ARTHROSCOPY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201527, CMP202405	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP	
30115	EXCIS, NASAL POLYP(S), EXTENSIVE	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
30400	RHINOPLASTY, PRIMARY; LATERAL AND ALAR CARTILAGES AND/OR ELEVATION OF NASAL TIP	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP200509	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
30410	RHINOPLASTY, PRIMARY; COMPLETE, EXTERNAL PARTS INCLUDING BONY PYRAMID, LATERAL AND ALAR CARTILAGES, AND/OR ELEVATION OF NASAL TIP	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP200509	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
30420	RHINOPLASTY, PRIMARY; INCLUDING MAJOR SEPTAL REPAIR	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP200509	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
30430	RHINOPLASTY, SECONDARY; MINOR REVISION (SMALL AMOUNT OF NASAL TIP WORK)	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP200509	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
30435	RHINOPLASTY, SECONDARY; INTERMEDIATE REVISION (BONY WORK WITH OSTEOTOMIES)	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP200509	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
30450	RHINOPLASTY, SECONDARY; MAJOR REVISION (NASAL TIP WORK AND OSTEOTOMIES)	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP200509	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
30460	RHINOPLASTY FOR NASAL DEFORMITY SECONDARY TO CONGENITAL CLEFT LIP AND/OR PALATE, INCLUDING COLUMELLAR LENGTHENING; TIP ONLY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP200509	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
30462	RHINOPLASTY FOR NASAL DEFORMITY SECONDARY TO CONGENITAL CLEFT LIP AND/OR PALATE, INCLUDING COLUMELLAR LENGTHENING; TIP, SEPTUM, OSTEOTOMIES	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP200509	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	

Codes	Code Description	Medical Mutual Commercial	Medical Mutual Commercial Criteria	Medicare Advantage	Medicare Advantage Criteria	Details/Notes
30465	REPAIR OF NASAL VESTIBULAR STENOSIS (EG. SPREADER GRAFTING, LATERAL NASAL WALL RECONSTRUCTION)	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP200509	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP	
30520	SEPTOPLASTY OR SUBMUCOUS RESECTION, WITH OR WITHOUT CARTILAGE SCORING, CONTOURING OR REPLACEMENT WITH GRAFT	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP200509, MCG A-0578 (CMP202406)	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
30620	SEPTAL OR OTHER INTRANASAL DERMATOPLASTY (DOES NOT INCLUDE OBTAINING GRAFT)	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP200509	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
30999	ABLATION, SOFT TISSUE OF INFERIOR TURBINATES, UNILATERAL OR BILATERAL, ANY METHOD (EG, ELECTROCAUTERY, RADIOFREQUENCY ABLATION, OR TISSUE VOLUME REDUCTION); INTRAMURAL (IE, SUBMUCOSAL)	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP202305, CMP200509, CMP202405	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP	
31237	NASAL/SINUS NDSC SURG W/BX POLYPECT/DBRDMT SPX	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
31253	NASAL/SINUS ENDOSCOPY, SURG W/ETHMOIDECTOMY; TOTAL (ANT/POST)	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
31254	NASAL/SINUS ENDOSCOPY W/ETHMOIDECTOMY PARTIAL	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES (See Notes)	MCG A-0578 (CMP202406)	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
31255	NASAL/SINUS ENDOSCOPY W/ETHMOIDECTOMY TOTAL	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES (See Notes)	MCG A-0578 (CMP202406)	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
31256	NASAL/SINUS ENDOSCOPY W/MAXILLARY ANTROSTOMY	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
31257	NASAL/SINUS ENDOSCOPY, SURG W/ETHMOIDECTOMY; TOTAL (ANT/POST) INCL SPHENOIDOTOMY	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
31259	NASAL/SINUS ENDOSCOPY, SURG W/ETHMOIDECTOMY; TOTAL W/SPHENOIDOTOMY & TISS REMOV	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
31267	NSL/SINUS NDSC MAX ANTROST W/RMVL TISS MAX SINUS	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
31276	NASAL/SINUS NDSC W/FRONTAL SINUS EXPLORATION	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
31287	NASAL/SINUS ENDOSCOPY, SURGICAL, WITH SPHENOIDOTOMY;	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
31288	NSL/SINUS NDSC SPHENDT RMVL TISS SPHENOID SINUS	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
31295	NASAL/SINUS NDSC SURG W/DILAT MAXILLARY SINUS	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
31296	NASAL/SINUS NDSC SURG W/DILATION FRONTAL SINUS	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
31297	NASAL/SINUS NDSC SURG W/DILATION SPHENOID SINUS	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
31298	NASAL/SINUS ENDOSCOPY, SURG; W/DILATION OF FRONTAL & SPHENOID SINUS OSTIA	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
31299	UNLISTED PROCEDURE, ACCESSORY SINUSES	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP202405	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
31571	LARYNGOSCOPY, DIRECT, W/ INJ INTO VOCAL CORDS; W/OPERATING MICROSCOPE	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	Botox: requires Prior Authorization under Medical Drug.
31599	UNLISTED PROCEDURE, LARYNX	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP202405	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
31830	REVISION OF TRACHEOSTOMY SCAR	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
31899	UNLISTED PROCEDURE, TRACHEA, BRONCHI	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP202405	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP	
32491	REMOVAL OF LUNG, OTHER THAN PNEUMONECTOMY; W/RESECTION\PLICATION OF EMPHYSEMATOUS LUNG(S) (BULLOUS OR NON\BULLOUS) FOR LUNG VOLUME REDUCTION, STERNAL SPLIT OR TRANSTHORACIC APPROACH, INCLUDES ANY PLEURAL PROCEDURE, WHEN PERFORMED	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
32664	THORACOSCOPY, SURGICAL; WITH THORACIC SYMPATHECTOMY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY (See Notes)	CMP200313	PRIOR AUTHORIZATION REQUIRED-MEDICAL POLICY-SEE NOTES	CMP	Please refer to the Corporate Medical Policy to determine if condition requires prior authorization.
32672	THORACOSCOPY, SURGICAL; WITH RESECTION\PLICATION FOR EMPHYSEMATOUS LUNG (BULLOUS OR NON\BULLOUS) FOR LUNG VOLUME REDUCTION (LVRS), UNILATERAL INCLUDES ANY PLEURAL PROCEDURE, WHEN PERFORMED	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	

Codes	Code Description	Medical Mutual Commercial	Medical Mutual Commercial Criteria	Medicare Advantage	Medicare Advantage Criteria	Details/Notes
32998	ABLATION THERAPY FOR REDUCTION OR ERADICATION OF ONE OR MORE PULMONARY TUMOR(S) INCLUDING PLEURA OR CHEST WALL WHEN INVOLVED BY TUMOR EXTENSION, PERCUTANEOUS, INCLUDING IMAGING GUIDANCE WHEN PERFORMED, UNILATERAL; RADIOFREQUENCY	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES (See Notes)	MCG A-0718 (CMP202406)	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
33140	TRANSMYOCARDIAL LASER REVASCULARIZATION, BY THORACOTOMY (SEPARATE PROCEDURE)	PRIOR AUTHORIZATION **NOT** REQUIRED (See notes)	None	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	Prior authorization required for Medicare Advantage only.
33141	TRANSMYOCARDIAL LASER REVASCULARIZATION, BY THORACOTOMY; PERFORMED AT THE TIME OF OTHER OPEN CARDIAC PROCEDURE(S) (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)	PRIOR AUTHORIZATION **NOT** REQUIRED (See notes)	None	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	Prior authorization required for Medicare Advantage only.
33274	TRANSCATHETER INSERTION OR REPLACEMENT OF PERMANENT LEADLESS PACEMAKER, RIGHT VENTRICULAR, INCLUDING IMAGING GUIDANCE (EG, FLUOROSCOPY, VENOUS ULTRASOUND, VENTRICULOGRAPHY, FEMORAL VENOGRAPHY) AND DEVICE EVALUATION (EG, INTERROGATION OR PROGRAMMING), WHEN PERFORMED	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP 202504	PRIOR AUTHORIZATION REQUIRED-FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
33275	TRANSCATHETER REMOVAL OF PERMANENT LEADLESS PACEMAKER, RIGHT VENTRICULAR, INCLUDING IMAGING GUIDANCE (EG, FLUOROSCOPY, VENOUS ULTRASOUND, VENTRICULOGRAPHY, FEMORAL VENOGRAPHY), WHEN PERFORMED	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP 202504	PRIOR AUTHORIZATION REQUIRED-FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
33276	INSERTION OF PHRENIC NERVE STIMULATOR SYSTEM (PULSE GENERATOR AND STIMULATING LEAD(S)), INCLUDING VESSEL CATHETERIZATION, ALL IMAGING GUIDANCE, AND PULSE GENERATOR INITIAL ANALYSIS WITH DIAGNOSTIC MODE ACTIVATION, WHEN PERFORMED	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
33278	REMOVAL OF PHRENIC NERVE STIMULATOR, INCLUDING VESSEL CATHETERIZATION, ALL IMAGING GUIDANCE, AND INTERROGATION AND PROGRAMMING, WHEN PERFORMED; SYSTEM, INCLUDING PULSE GENERATOR AND LEAD(S)	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
33477	TRANSCATHETER PULMONARY VALVE IMPLANTATION, PERCUTANEOUS APPROACH, INCLUDING PRE-STENTING OF THE VALVE DELIVERY SITE, WHEN PERFORMED	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201426	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP	
33927	IMPLANTATION OF A TOTAL REPLACEMENT HEART SYSTEM (ARTIFICIAL HEART) WITH RECIPIENT CARDIECTOMY	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
33928	REMOVAL AND REPLACEMENT OF TOTAL REPLACEMENT HEART SYSTEM (ARTIFICIAL HEART)	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
33929	REMOVAL OF TOTAL REPLACEMENT HEART SYSTEM (ARTIFICIAL HEART) FOR HEART TRANSPLANTATION (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
33975	INSERTION OF VENTRICULAR ASSIST DEVICE; EXTRACORPOREAL, SINGLE VENTRICLE	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
33976	INSERTION OF VENTRICULAR ASSIST DEVICE; EXTRACORPOREAL,BIVENTRICULAR	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
33979	INSERTION OF VENTRICULAR ASSIST DEVICE, IMPLANTABLE INTRACORPOREAL, SINGLE VENTRICLE	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
33981	REPLACEMENT OF EXTRACORPOREAL VENTRICULAR ASSIST DEVICE, SINGLE OR BIVENTRICULAR, PUMP(S), SINGLE OR EACH PUMP	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
33982	REPLACEMENT OF VENTRICULAR ASSIST DEVICE PUMP(S); IMPLANTABLE INTRACORPOREAL, SINGLE VENTRICLE, WITHOUT CARDIOPULMONARY BYPASS	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
33983	REPLACEMENT OF VENTRICULAR ASSIST DEVICE PUMP(S); IMPLANTABLE INTRACORPOREAL, SINGLE VENTRICLE, WITH CARDIOPULMONARY BYPASS	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
33988	INSERTION OF LEFT HEART VENT BY THORACIC INCISION (EG, STERNOTOMY, THORACOTOMY) FOR ECMO/ECLS	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
33990	INSERTION OF VENTRICULAR ASSIST DEVICE, PERCUTANEOUS INCLUDING RADIOLOGICAL SUPERVISION AND INTERPRETATION; LEFT HEART, ARTERIAL ACCESS ONLY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201804	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
33991	INSERTION OF VENTRICULAR ASSIST DEVICE, PERCUTANEOUS INCLUDING RADIOLOGICAL SUPERVISION AND INTERPRETATION; LEFT HEART, BOTH ARTERIAL AND VENOUS ACCESS, WITH TRANSSEPTAL PUNCTURE	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201804	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
33993	REPOSITIONING OF PERCUTANEOUS RIGHT OR LEFT HEART VENTRICULAR ASSIST DEVICE WITH IMAGING GUIDANCE AT SEPARATE AND DISTINCT SESSION FROM INSERTION	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201804	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP	
33995	INSERTION OF VENTRICULAR ASSIST DEVICE, PERCUTANEOUS, INCLUDING RADIOLOGICAL SUPERVISION AND INTERPRETATION; RIGHT HEART, VENOUS ACCESS ONLY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201804	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	

Codes	Code Description	Medical Mutual Commercial	Medical Mutual Commercial Criteria	Medicare Advantage	Medicare Advantage Criteria	Details/Notes
33999	UNLISTED PROCEDURE, CARDIAC SURGERY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP202405	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
35206	REPAIR BLOOD VESSEL, DIRECT; UPPER EXTREMITY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP202011	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP	
35226	REPAIR BLOOD VESSEL, DIRECT; LOWER EXTREMITY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP202011	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP	
35236	REPAIR BLOOD VESSEL WITH VEIN GRAFT; UPPER EXTREMITY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP202011	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP	
35266	REPAIR BLOOD VESSEL WITH GRAFT OTHER THAN VEIN; UPPER EXTREMITY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP202011	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP	
36465	INJECTION OF NON-COMPOUNDED FOAM SCLEROSANT WITH ULTRASOUND COMPRESSION MANEUVERS TO GUIDE DISPERSION OF THE INJECTATE, INCLUSIVE OF ALL IMAGING GUIDANCE AND MONITORING; SINGLE INCOMPETENT EXTREMITY TRUNCAL VEIN (EG, GREAT SAPHENOUS VEIN, ACCESSORY SAPHENOUS VEIN)	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY (See Notes)	CMP202014, MCG A-0170	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	Prior authorization not required for the initial 8 treatments. Any additional treatments please refer to MCG criteria.
36466	INJECTION OF NON-COMPOUNDED FOAM SCLEROSANT WITH ULTRASOUND COMPRESSION MANEUVERS TO GUIDE DISPERSION OF THE INJECTATE, INCLUSIVE OF ALL IMAGING GUIDANCE AND MONITORING; MULTIPLE INCOMPETENT TRUNCAL VEINS (EG, GREAT SAPHENOUS VEIN, ACCESSORY SAPHENOUS VEIN)SAME LEG	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY (See Notes)	CMP202014, MCG A-0170	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	Prior authorization not required for the initial 8 treatments. Any additional treatments please refer to MCG criteria. MA allows 3 sessions/leg
36468	INJECTIONS OF SCLEROSING SOLUTIONS, SPIDER VEINS;LIMB OR TRUNK	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201929	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
36470	INJECTION OF SCLEROSANT; SINGLE INCOMPETENT VEIN (OTHER THAN TELANGIECTASIA)	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY (See Notes)	CMP202014, MCG A-0170	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	Prior authorization not required for the initial 8 treatments. Any additional treatments please refer to MCG criteria.
36471	INJECTION OF SCLEROSING SOLUTION; MULTIPLE INCOMPETENT VEINS, (OTHER THAN TELANGIECTASIA), SAME LEG	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY (See Notes)	CMP202014, MCG A-0170	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	Prior authorization not required for the initial 8 treatments. Any additional treatments please refer to MCG criteria. MA allows 3 sessions/leg
36475	ENDOVENOUS ABLATION THERAPY OF INCOMPETENT VEIN, EXTREMITY, INCLUSIVE OF ALL IMAGING GUIDANCE AND MONITORING, PERCUTANEOUS, RADIOFREQUENCY; FIRST VEIN TREATED	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
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 REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
36478	ENDOVENOUS ABLATION THERAPY OF INCOMPETENT VEIN, EXTREMITY, INCLUSIVE OF ALL IMAGING GUIDANCE AND MONITORING, PERCUTANEOUS, LASER; FIRST VEIN TREATED	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
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 REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
36482	ENDOVENOUS ABLATION THERAPY OF INCOMPETENT VEIN, EXTREMITY, BY TRANSCATHETER DELIVERY OF A CHEMICAL ADHESIVE (EG, CYANOACRYLATE) REMOTE FROM THE ACCESS SITE, INCLUSIVE OF ALL IMAGING GUIDANCE AND MONITORING, PERCUTANEOUS; FIRST VEIN TREATED	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
36483	ENDOVENOUS ABLATION THERAPY OF INCOMPETENT VEIN, EXTREMITY, BY TRANSCATHETER DELIVERY OF A CHEMICAL ADHESIVE (EG, CYANOACRYLATE) REMOTE FROM THE ACCESS SITE, INCLUSIVE OF ALL IMAGING GUIDANCE AND MONITORING, PERCUTANEOUS; SUBSEQUENT VEIN(S) TREATED IN A SINGLE EXTREMITY, EACH THROUGH SEPARATE ACCESS SITES (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
37718	LIGATION SHORT SAPHENOUS VEIN	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
37722	LIGATION DIVISION & STRIPPING LONG SAPHENOFEMORAL VEIN JUNCTION TO KNEE OR BELOW	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
37780	LIG/DIV SHORT SAPHNS SAPHNPOPL	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
37799	UNLISTED PROCEDURE, VASCULAR SURGERY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP202011, CMP202405	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
38232	BONE MARROW HARVESTING FOR TRANSPLANTATION; AUTOLOGOUS	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP202107	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP	

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38241	MARROW/BLD-DRV PRPH STEM CELL TRNSPLJ AUTOL	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
38242	ALLOGENIC LYMPHOCYTE INFUSIONS	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
38308	LYMPHANGIOTOMY OR OTHER OPERATIONS ON LYMPHATIC CHANNELS	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP202011	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP	
38999	UNLISTED PROCEDURE, HEMIC OR LYMPHATIC SYSTEM	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP202011, CMP202405	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
41899	UNLISTED PROCEDURE, DENTOALVEOLAR STRUCTURES	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP202010, CMP202405	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
42299	UNLISTED PROCEDURE, PALATE, UVULA LASER ASSISTED UVOLOPLASTY (LAUP); SOMNOPLASTY ARE INVESTIGATIONAL	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP202405	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP	
42830	ADENOIDECTOMY, PRIMARY; UNDER AGE 12	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
43201	ESOPHAGOSCOPY, FLEXIBLE, TRANSORAL; WITH DIRECTED SUBMUCOSAL INJECTION(S), ANY SUBSTANCE	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP200310	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
43236	ESOPHAGOGASTRODUODENOSCOPY, FLEXIBLE, TRANSORAL; WITH DIRECTED SUBMUSOCAL INJECTION(S), ANY SUBSTANCE	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP200310	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
43289	UNLISTED LAPAROSCOPY PROCEDURE, ESOPHAGUS	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP200310, CMP202405	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
43497	LOWER ESOPHAGEAL MYOTOMY, TRANSORAL (IE, PERORAL ENDOSCROPIC MYOTOMY [POEM])	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP202101	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP	
43499	UNLISTED PROCEDURE, ESOPHAGUS GASTROESOPHAGEAL REFLUX DISEASE (GERD) TREATMENT DEVICES ARE INVESTIGATIONAL.	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP200310, CMP202101, CMP202405	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
43632	GASTRECTOMY, PARTIAL, DISTAL; WITH GASTROJEJUNOSTOMY	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
43633	GASTRECTOMY, PARTIAL, DISTAL; W/ROUX EN Y RECONSTRUCTION	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
43644	LAPAROSCOPY, SURGICAL, GASTRIC RESTRICTIVE PROCEDURE; WITH GASTRIC BYPASS AND ROUX\EN\Y GASTROENTEROSTOMY (ROUX LIMB 150 CM OR LESS)	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP94030	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
43645	LAPAROSCOPY, SURGICAL, GASTRIC RESTRICTIVE PROCEDURE; WITH GASTRIC BYPASS AND SMALL INTESTINE RECONSTRUCTION TO LIMIT ABSORPTION	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP94030	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
43659	UNLISTED LAPAROSCOPY PROCEDURE, STOMACH	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES (See Notes)	CMP94030, CMP202405	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
43770	LAPAROSCOPY, SURGICAL, GASTRIC RESTRICTIVE PROCEDURE; PLACEMENT OF ADJUSTABLE GASTRIC RESTRICTIVE DEVICE (EG, GASTRIC BAND AND SUBCUTANEOUS PORT COMPONENTS	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP94030	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
43771	LAPAROSCOPY, SURGICAL, GASTRIC RESTRICTIVE PROCEDURE; REVISION OF ADJUSTABLE GASTRIC RESTRICTIVE DEVICE COMPONENT ONLY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP94030	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP	
43772	LAPRSCPY GASTRIC RESTRICT REMOVAL ADJSTBL GASTRIC RESTRICT DEVICE COMPONENT ONLY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP94030	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
43773	LAPAROSCOPY, SURGICAL, GASTRIC RESTRICTIVE PROCEDURE; REMOVAL AND REPLACEMENT OF ADJUSTABLE GASTRIC RESTRICTIVE DEVICE COMPONENT ONLY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP94030	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP	
43774	REMOVAL OF ADJUSTABLE GASTRIC RESTRICTIVE DEVICE AND SUB-Q PORT COMPONENTS	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP94030	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
43775	LAPAROSCOPY, SURGICAL, GASTRIC RESTRICTIVE PROCEDURE; LONGITUDINAL GASTRECTOMY (IE, SLEEVE GASTRECTOMY)	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP94030	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
43842	GASTRIC RESTRICTIVE PROCEDURE, WITHOUT GASTRIC BYPASS, FOR MORBID OBESITY; VERTICAL\BANDED GASTROPLASTY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP94030	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
43843	GASTRIC RESTRICTIVE PROCEDURE, WITHOUT GASTRIC BYPASS, FOR MORBID OBESITY; OTHER THAN VERTICAL\BANDED GASTROPLASTY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP94030	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP	
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 REQUIRED - MEDICAL POLICY	CMP94030	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
43846	GASTRIC RESTRICTIVE PROCEDURE, WITH GASTRIC BYPASS FOR MORBID OBESITY; WITH SHORT LIMB (150 CM OR LESS) ROUX EN Y GASTROENTEROSTOMY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP94030	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
43847	GASTRIC RESTRICTIVE PROCEDURE, WITH GASTRIC BYPASS FOR MORBID OBESITY: WITH SMALL INTESTINE RECONSTRUCTION TO LIMIT ABSORPTION	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP94030	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	

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43848	REVISION, OPEN, OF GASTRIC RESTRICTIVE PROCEDURE FOR MORBID OBESITY, OTHER THAN ADJUSTABLE GASTRIC RESTRICTIVE DEVICE (SEPARATE PROCEDURE)	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP94030	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP	
43886	GASTRIC RESTRICTIVE PROCEDURE, OPEN; REVISION OF SUBCUTANEOUS PORT COMPONENT ONLY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP94030	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP	
43888	GASTRIC RESTRICTIVE PROCEDURE, OPEN; REMOVAL AND REPLACEMENT OF SUBCUTANEOUS PORT COMPONENT ONLY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP94030	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP	
43999	UNLISTED PROCEDURE, STOMACH	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP94030, CMP200310, CMP202101, CMP202405	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP	
44100	BIOPSY OF INTESTINE BY CAPSULE, TUBE, PERORAL (ONE OR MORE SPECIMENS)	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
44705	PREPARATION OF FECAL MICROBIOTA FOR INSTILLATION, INCLUDING ASSESSMENT OF DONOR SPECIMEN	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP202301	PRIOR AUTHORIZATION NOT REQUIRED		
46999	UNLISTED PROCEDURE, ANUS	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201709, CMP202405	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP	
47370	LAPAROSCOPY, SURGICAL, ABLATION OF ONE OR MORE LIVER TUMOR(S); RADIOFREQUENCY	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES (See Notes)	MCG A-0718 (CMP202406)	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
47380	ABLATION, OPEN, OF ONE OR MORE LIVER TUMOR(S); RADIOFREQUENCY	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES (See Notes)	MCG A-0718 (CMP202406)	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
47382	ABLATION, ONE OR MORE LIVER TUMOR(S), PERCUTANEOUS, RADIOFREQUENCY	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES (See Notes)	MCG A-0718 (CMP202406)	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
47399	UNLISTED PROCEDURE, LIVER	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP202015	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
48160	PANCREATECTOMY, TOTAL OR SUBTOTAL, WITH AUTOLOGOUS TRANSPLANTATION OF PANCREAS OR PANCREATIC ISLET CELLS	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201102	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP	
48999	UNLISTED PROCEDURE, PANCREAS	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201102, CMP202405	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP	
49904	OMENTAL FLAP, EXTRA\ABDOMINAL (EG, FOR RECONSTRUCTION OF STERNAL AND CHEST WALL DEFECTS)	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
49906	FREE OMENTAL FLAP WITH MICROVASCULAR ANASTOMOSIS	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP202011 CMP 201929	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
50250	ABLATION, OPEN, ONE OR MORE RENAL MASS LESION(S), CRYOSURGICAL, INCLUDING INTRAOPERATIVE ULTRASOUND GUIDANCE AND MONITORING, IF PERFORMED	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP200802	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP	
50542	LAPAROSCOPY, SURGICAL; ABLATION OF RENAL MASS LESION(S), INCLUDING INTRAOPERATIVE ULTRASOUND GUIDANCE AND MONITORING, WHEN PERFORMED	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
50549	UNLISTED LAPAROSCOPY PROCEDURE, RENAL	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP202405	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP	
50592	ABLATION, ONE OR MORE RENAL TUMOR(S), PERCUTANEOUS, UNILATERAL, RADIOFREQUENCY	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES (See Notes)	MCG A-0718 (CMP202406)	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
50593	ABLATION, RENAL TUMOR(S), UNILATERAL, PERCUTANEOUS, CRYOTHERAPY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP200802	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP	
51715	ENDOSCOPIC INJECTION OF IMPLANT MATERIAL INTO THE SUBMUCOSAL TISSUES OF THE URETHRA AND/OR BLADDER NECK	PRIOR AUTHORIZATION **NOT** REQUIRED (See notes)	None	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	Prior authorization required for Medicare Advantage only.
53445	INSERTION OF INFLATABLE URETHRAL/BLADDER NECK SPHINCTER, INCLUDING PLACEMENT OF PUMP, RESERVOIR, AND CUFF	PRIOR AUTHORIZATION **NOT** REQUIRED (See notes)	None	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	Prior authorization required for Medicare Advantage only.
53448	REMOVAL AND REPLACEMENT OF INFLATABLE URETHRAL/BLADDER NECK SPHINCTER INCLUDING PUMP, RESERVOIR, AND CUFF THROUGH AN INFECTED FIELD AT THE SAME OPERATIVE SESSION INCLUDING IRRIGATION AND DEBRIDEMENT OF INFECTED TISSUE	PRIOR AUTHORIZATION **NOT** REQUIRED (See notes)	None	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	Prior authorization required for Medicare Advantage only.
53899	UNLISTED PROCEDURE, URINARY SYSTEM 1. EXTRACORPOREAL MAGNETIC STIMULATION IS INVESTIGATIONAL 2. RADIOFREQUENCY THERAPY FOR URINARY INCONTINENCE IS INVESTIGATIONAL	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP200520, CMP202405	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP	
55899	UNLISTED PROCEDURE, MALE GENITAL SYSTEM	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP202302, CMP202405	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
56625	Vulvectomy, simple complete	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP 201609	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201609	Service only requires prior authorization for gender affirming/gender reassignment surgery (subject to members eligibility for this benefit).

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57106	VAGINECTOMY PARTIAL REMOVAL VAGINAL WALL	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP 201609	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201609	Service only requires prior authorization for gender affirming /gender reassignment surgery (subject to members eligibility for this benefit).
57295	REVISION (INCLUDING REMOVAL) OF PROSTHETIC VAGINAL GRAFT; VAGINAL APPROACH	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP 201609	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP 201609	Service only requires prior authorization for gender affirming /gender reassignment surgery (subject to members eligibility for this benefit).
56800	PLASTIC REPAIR INTROITUS	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP 201609	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201609	Service only requires prior authorization for gender affirming /gender reassignment surgery (subject to members eligibility for this benefit).
56810	PERINEOPLASTY, NONOBSTETRICAL	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201609	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP	
57335	VAGINOPLASTY FOR INTERSEX STATE	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201609	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP	
58140	MYOMECTOMY, 1-4 INTRAMURAL MYOMAS; ABDOM APPROACH	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
58145	MYOMCTMY EXC FIBRD TUMR UTERS	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
58146	MYOMECTOMY EXCIS FIBROID 5 OR MORE INTRAM > 250 GRA	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
58150	TOTAL ABDOM HYSTERECTOMY W OR W/O REMOVAL TUBES/OVARIES	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY (See Notes)	CMP201609, MCG S-650	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES (See Notes)	MCG	Prior authorization not required for personal history of cancer.
58180	SUPRACERVICAL ABDOM HYSTERECTOMY, W OR W/O REMOVAL TUBES/OVARIES	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES (See Notes)	MCG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES (See Notes)	MCG	Prior authorization not required for personal history of cancer.
58210	RAD ABDOM HYSTERECTOMY, W/BILAT TOTAL PELVIC LYMPHADENECTOMY	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES (See Notes)	MCG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES (See Notes)	MCG	Prior authorization not required for personal history of cancer.
58260	VAGINAL HYSTERECTOMY UTERUS 250 GM/<	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES (See Notes)	MCG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES (See Notes)	MCG	Prior authorization not required for personal history of cancer.
58262	VAG HYSTERECTOMY, FOR UTERUS 250 GM OR LESS; W/REMOVAL TUBE(S) AND/OR OVARY(S)	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY (See Notes)	CMP201609, MCG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES (See Notes)	MCG	Prior authorization not required for personal history of cancer.
58263	W REMOVAL OF TUBES AND/OR OVARYS W REPAIR OF ENTEROCELE	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES (See Notes)	MCG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES (See Notes)	MCG	Prior authorization not required for personal history of cancer.
58270	VAGNL HYSTRCTMY; W/REPAIR ENTEROCELE	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES (See Notes)	MCG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES (See Notes)	MCG	Prior authorization not required for personal history of cancer.
58290	VAGINAL HYSTERECTOMY UTERUS > 250 GM	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES (See Notes)	MCG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES (See Notes)	MCG	Prior authorization not required for personal history of cancer.
58291	VAG HYSTER/UTERUS OVE 250 GMS/REMOVAL TUBE/OVARY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY (See Notes)	CMP201609, MCG S-650	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES (See Notes)	MCG	Prior authorization not required for personal history of cancer.
58292	VAGINAL HYSTERECTOMY, UTERUS > 250 GM; TUBE/OVARY/ENTEROCELE	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES (See Notes)	MCG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES (See Notes)	MCG	Prior authorization not required for personal history of cancer.
58541	LAPAROSCOPY SURGICAL SUPRACERVICAL HYSTERECTOMY FOR UTERUS 250 G OR LESS	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES (See Notes)	MCG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES (See Notes)	MCG	Prior authorization not required for personal history of cancer.
58542	LAPS SUPRACRV HYSTERECT 250 GM/< RMVL TUBE/OVARY	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES (See Notes)	MCG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES (See Notes)	MCG	Prior authorization not required for personal history of cancer.
58544	LAPS SUPRACRV HYSTEREC >250 G RMVL TUBE/OVARY	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES (See Notes)	MCG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES (See Notes)	MCG	Prior authorization not required for personal history of cancer.
58545	LAPS MYOMECTOMY EXC 1-4 MYOMAS 250 GM/<	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
58546	LAPS MYOMECTOMY EXC 5/> MYOMAS >250 GRAMS	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES (See Notes)	MCG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES (See Notes)	MCG	Prior authorization not required for personal history of cancer.
58548	LAPS W/RAD HYST W/BILAT LMPHADEC RMVL TUBE/OVARY	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES (See Notes)	MCG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES (See Notes)	MCG	Prior authorization not required for personal history of cancer.

Codes	Code Description	Medical Mutual Commercial	Medical Mutual Commercial Criteria	Medicare Advantage	Medicare Advantage Criteria	Details/Notes
58550	LAPS VAGINAL HYSTERECTOMY UTERUS 250 GM/<	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES (See Notes)	MCG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES (See Notes)	MCG	Prior authorization not required for personal history of cancer.
58552	LAPS W/VAG HYSTERECT 250 GM/< RMVL TUBE&/OVARY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY (See Notes)	CMP201609, MCG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES (See Notes)	MCG	Prior authorization not required for personal history of cancer.
58553	LAPS W/VAGINAL HYSTERECTOMY > 250 GRAMS	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES (See Notes)	MCG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES (See Notes)	MCG	Prior authorization not required for personal history of cancer.
58554	LAPS VAGINAL HYSTERECT > 250 GM RMVL TUBE&/OVARY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY (See Notes)	CMP201609, MCG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES (See Notes)	MCG	Prior authorization not required for personal history of cancer.
58558	HYSTEROSCOPY, SURG; W/SAMPLING	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES (See Notes)	MCG A-0286 Hysteroscopy, with or without Endometrial Resection, Ablation, or Myomectomy	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES (See Notes)	MCG	Prior authorization not required for personal history of cancer. Add special instructions.
58563	HYSTEROSCOPY, SURG; W/ENDOMETRIAL ABLATION	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY (See Notes)	MCG A-0286	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES (See Notes)	MCG	Prior authorization not required for personal history of cancer. Add special instructions.
58565	HYSTEROSCOPY W/BILAT FT CANNULATION TO INDUCE OCCLUSION BY PERM IMPLANT PLACEMEN	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES (See Notes)	MCG	PRIOR AUTHORIZATION REQUIRED-FOLLOW MEDICARE COVERAGE CRITERIA (See Notes)	CMS	Prior authorization not required for personal history of cancer. Add special instructions.
58570	LAPAROSCOPY,SURGICAL, WITH TOTAL HYSTERECTOMY, FOR UTERUS 250 G OR LESS	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES (See Notes)	MCG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES (See Notes)	MCG	Prior authorization not required for personal history of cancer.
58571	WITH REMOVAL OF TUBE(S) AND/OR OVARY(S)	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY (See Notes)	CMP201609, MCG S-665	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES (See Notes)	MCG	Prior authorization not required for personal history of cancer.
58572	LAPAROSOCPY, SURGICAL, WITH TOTAL HYSTERECTOMY, FOR UTERUS GREATER THAN 250 G	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES (See Notes)	MCG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES (See Notes)	MCG	Prior authorization not required for personal history of cancer.
58573	LAPAROSOCPY, SURGICAL, W/ TOTAL HYSTERECTOMY, W/REMOVAL OF TUBE(S) /OVARY(S)	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY (See Notes)	CMP201609, MCG S-665	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES (See Notes)	MCG	Prior authorization not required for personal history of cancer.
58578	UNLISTED LAPAROSCOPY PROC, UTERUS	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP202405	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP	
58580	TRANSCERVICAL ABLATION OF UTERINE FIBROID(S), INCLUDING INTRAOPERATIVE ULTRASOUND GUIDANCE AND MONITORING, RADIOFREQUENCY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY (See Notes)	CMP202404	PRIOR AUTHORIZATION NOT REQUIRED		
58660	LAPAROSCOPY W/LYSIS OF ADHESIONS	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES (See Notes)	MCG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES (See Notes)	MCG	Prior authorization not required for personal history of cancer.
58661	LAPAROSCOPY W/RMVL ADNEXAL STRUCTURES	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY (See Notes)	CMP201609, MCG S-775	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES (See Notes)	MCG	Prior authorization not required for personal history of cancer.
58662	LAPS FULG/EXC OVARY VISCERA/PERITONEAL SURFACE	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES (See Notes)	MCG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES (See Notes)	MCG	Prior authorization not required for personal history of cancer.
58670	LAPAROSCOPY W/FULGURATION OF OVIDUCTS	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES (See Notes)	MCG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES (See Notes)	MCG	Prior authorization not required for personal history of cancer.
58720	SALPINGO-OOPHORECTOMY COMPLETE/PARTIAL, UNILAT/BILAT, SEPARATE PROC	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES (See Notes)	MCG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES (See Notes)	MCG	Prior authorization not required for personal history of cancer.
58953	BILAT SALPINGO-OOPHORECTOMY/TOTAL ABDOM HYSTERECTOMY	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES (See Notes)	MCG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES (See Notes)	MCG	Prior authorization not required for personal history of cancer.
58954	BILAT SALPINGO-OOPHORECTOMY/TOTAL ABDOM HYSTERECTOMY; W/PELVIC LYMPHADENECTOMY	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES (See Notes)	MCG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES (See Notes)	MCG	Prior authorization not required for personal history of cancer.
58999	UNLISTED PROCEDURE, FEMALE GENITAL SYSTEM NONOBSTETRICAL	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP200302, CMP202302, CMP202405	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP	
60699	UNLISTED PROCEDURE, ENDOCRINE SYSTEM	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP202405	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP	
61736	LASER INTERSTITIAL THERMAL THERAPY (LITT) OF LESION, INTRACRANIAL, INCLUDING BURR HOLE(S), WITH MAGNETIC RESONANCE IMAGING GUIDANCE, WHEN PERFORMED; SINGLE TRAJECTORY FOR 1 SIMPLE LESION	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP202207	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP	

Codes	Code Description	Medical Mutual Commercial	Medical Mutual Commercial Criteria	Medicare Advantage	Medicare Advantage Criteria	Details/Notes
61737	LASER INTERSTITIAL THERMAL THERAPY (LITT) OF LESION, INTRACRANIAL, INCLUDING BURR HOLE(S), WITH MAGNETIC RESONANCE IMAGING GUIDANCE, WHEN PERFORMED; MULTIPLE TRAJECTORIES FOR MULTIPLE OR COMPLEX LESION(S)	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP202207	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP	
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 **NOT** REQUIRED (See notes)	None	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	Prior authorization required for Medicare Advantage only.
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 **NOT** REQUIRED (See notes)	None	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	Prior authorization required for Medicare Advantage only.
61880	REVISION OR REMOVAL OF INTRACRANIAL NEUROSTIMULATOR ELECTRODES	PRIOR AUTHORIZATION **NOT** REQUIRED (See notes)	None	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	Prior authorization required for Medicare Advantage only.
62287	DECOMPRESSION PROCEDURE, PERCUTANEOUS, OF NUCLEUS PULPOSUS OF INTERVERTEBRAL DISK, 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 REQUIRED - MEDICAL POLICY (See Notes)	CMP2019-G	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	May require prior authorization. Refer to Corporate Medical Policy.
62321	INJ(S), OF DIAG OR THERAPEUTIC SUBSTANCE(S) INCL NEEDLE/CATH PLACEMENT; W/GUIDE	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
62323	INJ(S), OF DIAG OR THERAPEUTIC SUBSTANCE(S) LUMBAR OR SACRAL; W/ GUIDANCE	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
62324	INJ(S), INCL INDWELLING CATH, CERVICAL OR THORACIC; W/O GUIDANCE	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
62326	INJ(S), INCL INDWELLING CATH, LUMBAR OR SACRAL; W/O GUIDANCE	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
62360	IMPLANT/REPLACE DEVICE FOR DRUG INFUSION; SUBCUT RESERVOIR	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP95017	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
63001	LAMINECTOMY W/EXPLORATION SPINAL CORD; CERVICAL	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
63003	LAMINECTOMY W/EXPLORATION SPINAL CORD; THORACIC	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
63005	LAMINECTOMY W/O FFD 1/2 VERT SEG LUMBAR	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
63012	LAMINECTOMY W/ REMOVAL ABNORMAL FACETS, LUMBAR	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
63015	LAMINECTOMY W/EXPLORATION SPINAL CORD;, > 2 SEGMENTS; CERVICAL	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
63016	LAMNCTMY DECMPRSN SPNL CRD/CAU	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
63017	LAMINECTOMY W/EXPLORE/DECOMPRESS SPINAL CORD, W/O DISKECTOMY; LUMBAR	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
63020	LAMNOTMY INCL W/DCMPRSN NRV ROOT 1 INTRSPC CERVC	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP2019-G, MCG S-310	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
63030	LAMNOTMY INCL W/DCMPRSN NRV ROOT 1 INTRSPC LUMBR	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP2019-G, MCG S-810	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
63035	LAMNOTMY W/DCMPRSN NRV EACH ADDL CRVCL/LMBR	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP2019-G, MCG S-810	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
63040	LAMINOTOMY W/ DECOMPRESSION NERVE ROOTS; REEXPLORE, SINGLE INTERSPACE, CERV	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
63042	LAMOT PRTL FFD EXC DISC REEXPL 1 NTRSPC LUMBAR	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
63044	LAMOT W/PRTL FFD HRNA8 REEXPL 1 NTRSPC EA LMBR	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
63045	LAMINECTOMY, SINGLE VERT SEGMENT; CERVICAL	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	

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63046	LAMINECTOMY, SINGLE VERT SEGMENT; THORACIC	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
63047	LAMINECTOMY, SINGLE VERT SEGMENT; LUMBAR	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
63048	LAMINECTOMY EA ADDL SEGMENT	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
63050	C-LAMINOPLASTY W/DECOMPRESS OF CORD 2/MORE SEGS	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
63051	C-LAMINOPLASTY W/DECOMPRESS OF 2/MORE SEGS & BONY RECONSTRUCTION	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
63055	TRANSPEDICULAR APPR FOR DECOMP	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
63056	TRANSPEDICULAR DCMPRN SPINAL CORD 1 SEG LUMBAR	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
63075	DISKECTOMY, ANT, W/ DECOMPRESSION SPINAL CORD; CERV, SINGLE INTERSPACE	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
63081	VERTEBRAL CORPECTOMY, PARTIAL/COMPLETE, ANT APPROACH; CERV, SINGLE SEGMENT	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
63085	VERTEBRAL CORPECTOMY, PARTIAL/COMP, TRANSTHORACIC APPROACH;THORACIC,SING SEGMENT	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
63090	VERTEBRAL CORPECTOMY, PARTIAL/COMP, LOW THORACIC/LUMBAR/SACRAL; SINGLE SEGMENT	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
63172	LAMINECTOMY WITH DRAINAGE CYST/SYRINX; TO SUBARACHNOID SPACE	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
63185	LAMNCTMY RHIZOTMY;ONE/TWO SEGM	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
63190	LAMNCTMY RHIZTMY;MORE THAN 2 S	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
63265	LAMINECTOMY EXCISION INTRASPINAL LESION OTHER THAN NEOPLASM,EXTRADURAL; CERVICAL	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
63266	LAMINECTOMY EXCISION INTRASPINAL LESION OTHER THAN NEOPLASM,EXTRADURAL; THORACIC	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
63267	LAMINECTOMY EXCISION INTRASPINAL LESION OTHER THAN NEOPLASM, EXTRADURAL; LUMBAR	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
63277	LAMINECTOMY FOR BIOPSY/EXCISION INTRASPINAL NEOPLASM; EXTRADURAL, LUMBAR	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
63650	PERCUTANEOUS IMPLANTATION OF NEUROSTIMULATOR ELECTRODE ARRAY, EPIDURAL	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
63655	LAMINECTOMY FOR IMPLANTATION OF NEUROSTIMULATOR ELECTRODES, PLATE/PADDLE, EPIDURAL	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
63661	REMOVAL OF SPINAL ELECTRODE ARRAYS PERCUTANEOUSLY	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
63662	REMOVAL OF SPINAL ELECTRODE PLATES OR PADDLES BY LAMINOTOMY OR LAMINECTOMY	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
63663	REVISION INCLUDING REPLACEMENT, WHEN PERFORMED, OF SPINAL NEUROSTIMULATOR ELECTRODE PERCUTANEOUS ARRAY(S), INCLUDING FLUOROSCOPY, WHEN PERFORMED	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
63664	REVISION INCLUDING REPLACEMENT, WHEN PERFORMED, OF SPINAL NEUROSTIMULATOR ELECTRODE PLATE/PADDLE(S) PLACED VIA LAMINOTOMY OR LAMINECTOMY, INCLUDING FLUOROSCOPY, WHEN PERFORMED	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
63685	INSERTION OR REPLACEMENT OF SPINAL NEUROSTIMULATOR PULSE GENERATOR OR RECEIVER, DIRECT OR INDUCTIVE COUPLING	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
63688	REVJ/RMVL IMPLANTED SPINAL NEUROSTIM GENERATOR	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
64479	NJX ANES&/STRD W/IMG TFRML EDRL CRV/THRC 1 LVL	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
64483	NJX ANES&/STRD W/IMG TFRML EDRL LMBR/SAC 1 LVL	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
64490	NJX DX/THER AGT PVRT FACET JT CRV/THRC 1 LEVEL	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
64493	NJX DX/THER AGT PVRT FACET JT LMBR/SAC 1 LEVEL	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	

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64555	PERCUTANEOUS IMPLANTATION OF NEUROSTIMULATOR ELECTRODE ARRAY; PERIPHERAL NERVE (EXCLUDES SACRAL NERVE)	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201004	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
64561	PERCUTANEOUS IMPLANTATION OF NEUROSTIMULATOR ELECTRODE ARRAY; SACRAL NERVE (TRANSFORAMINAL PLACEMENT) INCLUDING IMAGE GUIDANCE, IF PERFORMED	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
64566	POSTERIOR TIBIAL NEUROSTIMULATION, PERCUTANEOUS NEEDLE ELECTRODE, SINGLE TREATMENT, INCLUDES PROGRAMMING	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG A-0699 (CMP202014)	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
64568	OPEN IMPLANTATION OF CRANIAL NERVE (EG, VAGUS NERVE) NEUROSTIMULATOR ELECTRODE ARRAY AND PULSE GENERATOR	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY or MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY or MILLIMAN CARE GUIDELINES	MCG	
64569	REVISION OR REPLACEMENT OF CRANIAL NERVE (EG, VAGUS NERVE) NEUROSTIMULATOR ELECTRODE ARRAY, INCLUDING CONNECTION TO EXISTING PULSE GENERATOR	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES (See Notes)	MCG B-821-T (CMP202406)	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
64570	REMOVAL OF CRANIAL NERVE (EG, VAGUS NERVE) NEUROSTIMULATOR ELECTRODE ARRAY AND PULSE GENERATOR	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES (See Notes)	MCG B-821-T (CMP202406)	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
64575	INCISION FOR IMPLANTATION OF NEUROSTIMULATOR ELECTRODE ARRAY; PERIPHERAL NERVE (EXCLUDES SACRAL NERVE)	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201004	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
64580	INCISION FOR IMPLANTATION OF NEUROSTIMULATOR ELECTRODE ARRAY; NEUROMUSCULAR	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201004	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
64581	INCISION FOR IMPLANTATION OF NEUROSTIMULATOR ELECTRODE ARRAY; SACRAL NERVE (TRANSFORAMINAL PLACEMENT)	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
64585	REVISION OR REMOVAL OF PERIPHERAL NEUROSTIMULATOR ELECTRODE ARRAY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201004	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
64590	INSERTION OR REPLACEMENT OF PERIPHERAL OR GASTRIC NEUROSTIMULATOR PULSE GENERATOR OR RECEIVER, DIRECT OR INDUCTIVE COUPLING	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201004, MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
64595	REVISION OR REMOVAL OF PERIPHERAL OR GASTRIC NEUROSTIMULATOR PULSE GENERATOR OR RECEIVER	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201004	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
64633	DSTR NROLYTC AGNT PARVERTEB FCT SNGL CRVCL/THORA	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
64634	DESTRUCTION BY NEUROLYTIC AGENT, PARAVERTEBRAL FACET JOINT NERVE(S), WITH IMAGING GUIDANCE (FLUOROSCOPY OR CT); CERVICAL OR THORACIC, EACH ADDITIONAL FACET JOINT (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
64635	DSTR NROLYTC AGNT PARVERTEB FCT SNGL LMBR/SACRAL	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
64636	DSTR NROLYTC AGNT PARVERTEB FCT ADDL LMBR/SACRAL	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
64640	DSTRJ NEUROLYTIC AGENT OTHER PERIPHERAL NERVE	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201537	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
64721	REVISE MEDIAN NERVE AT WRIST	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
64722	DECOMPRESSION; UNSPECIFIED NERVE(S)	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
64999	UNLISTED PROCEDURE, NERVOUS SYSTEM	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP2019-F, CMP2019-G, CMP201537, MCG A-0217 (CMP202407), CMP200522, CMP202207, CMP201004, CMP202405	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP	
65785	IMPLANTATION OF INTRASTROMAL CORNEAL RING SEGMENTS	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP200504	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP	

Codes	Code Description	Medical Mutual Commercial	Medical Mutual Commercial Criteria	Medicare Advantage	Medicare Advantage Criteria	Details/Notes
66989	EXTRACAPSULAR CATARACT REMOVAL WITH INSERTION OF INTRAOCULAR LENS PROSTHESIS (1 STAGE PROCEDURE), MANUAL OR MECHANICAL TECHNIQUE (EG IRRIGATION AND ASPIRATON OR PHACOEMULSIFICATION), COMPLEX, REQUIRING DEVICES OR TECHNIQUES NOT GENERALLY USED IN ROUTINE CATARACT SURGERY (EG. IRIS EXPANSION DEVICE, SUTURE SUPPORT FOR INTRAOCULAR LENS, OR PRIMARY POSTERIOR CAPSULORRHEXIS) OR PERFORMED ON PATIENTS IN THE AMBLYOGENIC DEVELOPMENTAL STAGE; WITH INSERTION OF INTRAOCULAR (EG, TRABECULAR MESHWORK, SUPRACILIARY, SUPRACHOROIDAL) ANTERIOR SEGMENT AQUEOUS DRAINAGE DEVICE, WITHOUT EXTRAOCULAR RESEVOIR, INTERNAL APPROACH, ONE OR MORE	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201721	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
66991	EXTRACAPSULAR CATARACT REMOVAL WITH INSERTION OF INTRAOCULAR LENS PROSTHESIS (1 STAGE PROCEDURE), MANUAL OR MECHANICAL TECHNIQUE (EG, IRRIGATION AND ASPIRATION OR PHACOEMULSIFICATION); WITH INSERTION OF INTRAOCULAR (EG, TRABECULAR MESHWORK, SUPRACILIARY, SUPRACHOROIDAL) ANTERIOR SEGMENT AQUEOUS DRAINAGE DEVICE, WITHOUT EXTRAOCULAR RESEVOIR, INTERNAL APPROACH, ONE OR MORE	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201721	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
66999	UNLISTED PROCEDURE, ANTERIOR SEGMENT OF EYE	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201721, CMP202405	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
67299	UNLISTED PROCEDURE, POSTERIOR SEGMENT	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP202405	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
67311	STRABISMUS SURGERY, RECESSION OR RESECTION PROCEDURE; ONE HORIZONTAL MUSCLE	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY (See Notes)	CMP95034	PRIOR AUTHORIZATION REQUIRED-MEDICAL POLICY-SEE NOTES	CMP	Prior authorization is only required for members ≥18 years old.
67312	STRABISMUS SURGERY, RECESSION OR RESECTION PROCEDURE; TWO HORIZONTAL MUSCLES	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY (See Notes)	CMP95034	PRIOR AUTHORIZATION REQUIRED-MEDICAL POLICY-SEE NOTES	CMP	Prior authorization is only required for members ≥18 years old.
67314	STRABISMUS SURGERY, RECESSION OR RESECTION PROCEDURE; ONE VERTICAL MUSCLE (EXCLUDING SUPERIOR OBLIQUE)	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY (See Notes)	CMP95034	PRIOR AUTHORIZATION REQUIRED-MEDICAL POLICY-SEE NOTES	CMP	Prior authorization is only required for members ≥18 years old.
67316	STRABISMUS SURGERY, RECESSION OR RESECTION PROCEDURE; TWO OR MORE VERTICAL MUSCLES (EXCLUDING SUPERIOR OBLIQUE)	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY (See Notes)	CMP95034	PRIOR AUTHORIZATION REQUIRED-MEDICAL POLICY-SEE NOTES	CMP	Prior authorization is only required for members ≥18 years old.
67318	STRABISMUS SURGERY, ANY PROCEDURE, SUPERIOR OBLIQUE MUSCLE	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY (See Notes)	CMP95034	PRIOR AUTHORIZATION REQUIRED-MEDICAL POLICY-SEE NOTES	CMP	Prior authorization is only required for members ≥18 years old.
67320	TRANSPOSITION PROCEDURE (EG, FOR PARETIC EXTRAOCULAR MUSCLE), ANY EXTRAOCULAR MUSCLE (SPECIFY) (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY (See Notes)	CMP95034	PRIOR AUTHORIZATION REQUIRED-MEDICAL POLICY-SEE NOTES	CMP	Prior authorization is only required for members ≥18 years old.
67331	STRABISMUS SURGERY ON PATIENT WITH PREVIOUS EYE SURGERY OR INJURY THAT DID NOT INVOLVE THE EXTRAOCULAR MUSCLES (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY (See Notes)	CMP95034	PRIOR AUTHORIZATION REQUIRED-MEDICAL POLICY-SEE NOTES	CMP	Prior authorization is only required for members ≥18 years old.
67332	STRABISMUS SURGERY ON PATIENT WITH SCARRING OF EXTRAOCULAR MUSCLES (EG, PRIOR OCULAR INJURY, STRABISMUS OR RETINAL DETACHMENT SURGERY) OR RESTRICTIVE MYOPATHY (EG, DYSTHYROID OPHTHALMOPATHY) (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY (See Notes)	CMP95034	PRIOR AUTHORIZATION REQUIRED-MEDICAL POLICY-SEE NOTES	CMP	Prior authorization is only required for members ≥18 years old.
67334	STRABISMUS SURGERY BY POSTERIOR FIXATION SUTURE TECHNIQUE, WITH OR WITHOUT MUSCLE RECESSION (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY (See Notes)	CMP95034	PRIOR AUTHORIZATION REQUIRED-MEDICAL POLICY-SEE NOTES	CMP	Prior authorization is only required for members ≥18 years old.
67335	PLACEMENT OF ADJUSTABLE SUTURE(S) DURING STRABISMUS SURGERY, INCLUDING POSTOPERATIVE ADJUSTMENT(S) OF SUTURE(S) (LIST SEPARATELY IN ADDITION TO CODE FOR SPECIFIC STRABISMUS SURGERY)	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY (See Notes)	CMP95034	PRIOR AUTHORIZATION REQUIRED-MEDICAL POLICY-SEE NOTES	CMP	Prior authorization is only required for members ≥18 years old.
67340	STRABISMUS SURGERY INVOLVING EXPLORATION AND/OR REPAIR OF DETACHED EXTRAOCULAR MUSCLE(S) (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY (See Notes)	CMP95034	PRIOR AUTHORIZATION REQUIRED-MEDICAL POLICY-SEE NOTES	CMP	Prior authorization is only required for members ≥18 years old.
67900	REPAIR OF BROW PTOSIS (SUPRACILIARY, MID FOREHEAD OR CORONAL APPROACH)	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP96018	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
67901	REPAIR OF BLEPHAROPTOSIS; FRONTALIS MUSCLE TECHNIQUE WITH SUTURE OR OTHER MATERIAL (EG, BANKED FASCIA)	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP96018	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
67902	REPAIR BLEPHAROPTOSIS; FRONTALIS MUSCLE TECHNIQUE WITH AUTOLOGOUS FACIAL SLING (INCLUDES OBTAINING FASCIA)	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP96018	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
67903	REPAIR BLEPHAROPTOSIS; (TARSO)LEVATOR RESECTION OR ADVANCEMENT, INTERNAL APPROACH	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP96018	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
67904	REPAIR BLEPHAROPTOSIS; (TARSO) LEVATOR RESECTION OR ADVANCEMENT, EXTERNAL APPROACH	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP96018	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	

Codes	Code Description	Medical Mutual Commercial	Medical Mutual Commercial Criteria	Medicare Advantage	Medicare Advantage Criteria	Details/Notes
67906	REPAIR BLEPHAROPTOSIS; SUPERIOR RECTUS TECHNIQUE WITH FASCIAL SLING (INCLUDES OBTAINING FASCIA)	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP96018	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
67908	REPAIR OF BLEPHAROPTOSIS; CONJUNCTIVO\TARSO\MULLER'S MUSCLE\LEVATOR RESECTION (EG, FASANELLA\SERVAT TYPE)	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP96018	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
67909	REDUCTION OF OVERCORRECTION OF PTOSIS	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
67911	CORRECTION OF LID RETRACTION	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED-FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
67916	REPAIR OF ECTROPION; EXCISION TARSAL WEDGE	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP96018	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
67917	REPAIR OF ECTROPION; EXTENSIVE	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP96018	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
67950	CANTHOPLASTY (RECONSTRUCTION OF CANTHUS)	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
67961	EXCISION AND REPAIR OF EYELID, INVOLVING LID MARGIN, TARSUS, CONJUNCTIVA, CANTHUS, OR FULL THICKNESS, MAY INCLUDE PREPARATION FOR SKIN GRAFT OR PEDICLE FLAP WITH ADJACENT TISSUE TRANSFEROR REARRANGEMENT; UP TO ONE FOURTH OF LID MARGIN	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
69300	OTOPLASTY, PROTRUDING EAR, WITH OR WITHOUT SIZE REDUCTION	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP200521	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
69705	NASOPHARYNGOSCOPY, SURGICAL, WITH DILATION OF EUSTACHIAN TUBE (IE, BALLOON DILATION); UNILATERAL	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP202305	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP	
69706	NASOPHARYNGOSCOPY, SURGICAL, WITH DILATION OF EUSTACHIAN TUBE (IE, BALLOON DILATION); BILATERAL	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP202305	PRIOR AUTHORIZATION **NOT** REQUIRED		Prior authorization not required for Medicare Advantage plans only.
69710	IMPLANTATION OR REPLACEMENT OF ELECTROMAGNETIC BONE CONDUCTION HEARING DEVICE IN TEMPORAL BONE	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP	
69711	REMOVAL OR REPAIR OF ELECTROMAGNETIC BONE CONDUCTION DEVICE	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
69714	IMPLANTATION, OSSEOINTEGRATED IMPLANT, TEMPORAL BONE, WITH PERCUTANEOUS ATTACHMENT TO EXTERNAL SPEECH PROCESSOR/COCHLEAR STIMULATOR; WITHOUT MASTOIDECTOMY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	MCG CMP 202020	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	Refer to CMP for hybrid cochlear implant services
69716	IMPLANTATION, OSSEOINTEGRATED IMPLANT, SKULL; WITH MAGNETIC TRANSCUTANEOUS ATTACHEMENT TO EXTERNAL SPEECH PROCESSOR	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	MCG CMP 202020	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	Refer to CMP for hybrid cochlear implant services
69717	REPLACEMENT (INCLUDING REMOVAL OF EXISTING DEVICE), OSSEOINTEGRATED IMPLANT, TEMPORAL BONE, WITH PERCUTANEOUS ATTACHMENT TO EXTERNAL SPEECH PROCESSOR/COCHLEAR STIMULATOR; WITHOUT MASTOIDECTOMY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	MCG CMP 202020	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	Refer to CMP for hybrid cochlear implant services
69719	REVISION OR REPLACEMENT (INCLUDING REMOVAL OF EXISTING DEVICE), OSSEOINTEGRATED IMPLANT, SKULL; WITH PERCUTANEOUS ATTACHMENT TO EXTERNAL SPEECH PROCESSOR	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	MCG CMP 202020	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	Refer to CMP for hybrid cochlear implant services
69729	IMPLANTATION, OSSEOINTEGRATED IMPLANT, SKULL; WITH MAGNETIC TRANSCUTANEOUS ATTACHMENT TO EXTERNAL SPEECH PROCESSOR, OUTSIDE OF THE MASTOID AND RESULTING IN REMOVAL OR GREATER THAN OR EQUAL TO 100 SQ MM SURGACE AREA OF BONE DEEP TO THE OUTER CRANIAL COTEX	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
69730	REPLACEMENT (INCLUDING REMOVAL OF EXISTING DEVICE), OSSEOINTEGRATED IMPLANT, SKULL;WITH MAGNETIC TRANSCUTANEOUS ATTACHMENT TO EXTERNAL SPEECH PROCESSOR, OUTSIDE THE MASTOID AND INVOLVING A BONY DEFECT GREATER THAN OR EQUAL TO 100 SQ MM SURGACE AREA OF BONE DEEP TO THE OUTER CRANIAL CORETEX	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
69799	UNLISTED PROCEDURE, MIDDLE EAR	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP202305, CMP202405	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP	
69930	COCHLEAR DEVICE IMPLANTATION, WITH OR WITHOUT MASTOIDECTOMY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP202020 MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
76499	UNLISTED DIAGNOSTIC RADIOGRAPHIC PROCEDURE	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP202011, CMP201324	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
76977	ULTRASOUND BONE DENSITY MEASUREMENT AND INTERPRETATION, PERIPHERAL SITE(S), ANY METHOD.	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY (See Notes)	CMP94022	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	Prior authorization required if conducted more frequently than every 2 years. See Corporate Medical Policy.
76999	UNLISTED ULTRASOUND PROCEDURE (EG, DIAGNOSTIC, INTERVENTIONAL)	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP202405	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
77080	DUAL ENERGY X RAY ABSORPTIOMETRY (DXA), BONE DENSITY STUDY, 1 OR MORE SITES; AXIAL SKELETON (EG, HIPS, PELVIS, SPINE)	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY (See Notes)	CMP94022	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	Prior authorization required if conducted more frequently than every 2 years. See Corporate Medical Policy.

Codes	Code Description	Medical Mutual Commercial	Medical Mutual Commercial Criteria	Medicare Advantage	Medicare Advantage Criteria	Details/Notes
77081	DUAL ENERGY XRAY ABSORPTIOMETRY (DXA), BONE DENSITY STUDY, 1 OR MORE SITES; APPENDICULAR SKELETON (PERIPHERAL) (EG, RADIUS, WRIST, HEEL)	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY (See Notes)	CMP94022	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	Prior authorization required if conducted more frequently than every 2 years. See Corporate Medical Policy.
77085	DUAL-ENERGY X-RAY ABSORPTIOMETRY (DXA), BONE DENSITY STUDY, 1 OR MORE SITES; AXIAL SKELETON (EG, HIPS, PELVIS, SPINE), INCLUDING VERTEBRAL FRACTURE ASSESSMENT	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP94022	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
77086	VERTEBRAL FRACTURE ASSESSMENT VIA DUAL-ENERGY X-RAY ABSORPTIOMETRY (DXA)	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP94022	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
80299	ASSAY OF QUANTITATION OF THERAPEUTIC DRUG, NOT ELSEWHERE SPECIFIED	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP202405	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP	
81105	HUMAN PLATELET ANTIGEN 1 GENOTYPING (HPA-1), ITGB3 (INTEGRIN, BETA 3 (PLATELET GLYCOPROTEIN IIIA), ANTIGEN CD61 (GPIIA) (EG, NEONATAL ALLOIMMUNE THROMBOCYTOPENIA (NAIT), POST-TRANSFUSION PURPURA), GENE ANALYSIS, COMMON VARIANT, HPA-1A/B (L33P)	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81106	HUMAN PLATELET ANTIGEN 2 GENOTYPING (HPA-2), GP1BA (GLYCOPROTEIN IB (PLATELET), ALPHA POLYPEPTIDE (GPIBA) (EG, NEONATAL ALLOIMMUNE THROMBOCYTOPENIA (NAIT), POST-TRANSFUSION PURPURA), GENE ANALYSIS, COMMON VARIANT, HPA-2A/B (T145m0	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81107	HUMAN PLATELET ANTIGEN 3 GENOTYPING (HPA-3), ITGA2B (INTEGRIN, ALPHA 2B (PLATELET GLYCOPROTEIN IIB OF IIB/IIIA COMPLEX), ANTIGEN CD41 (GPIIB) (EG, NEONATAL ALLOIMMUNE THROMBOCYTOPENIA (NAIT), POST-TRANSFUSION PURPURA), GENE ANALYSIS, COMMON VARIANT, HPA-3A/B (1843S)	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81108	HUMAN PLATELET ANTIGEN 4 GENOTYPING (HPA-4), ITGB3 (INTEGRIN, BETA 3 (PLATELET GLYCOPROTEIN IIIA), ANTIGEN CD61 (GPIIIA) (EG, NEONATAL ALLOIMMUNE THROMBOCYTOPENIA (NAIT), POST-TRANSFUSION PURPURA), GENE ANALYSIS, COMMON VARIANT, HPA-4A/B (R143Q)	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81109	HUMAN PLATELET ANTIGEN 5 GENOTYPING (HPA-5), ITGA2(INTEGRIN, ALPHA 2 (CD49B, ALPHA 2 SUBUNIT OF VLA-2 RECEPTOR) (GPIA) (EG, NEONATAL ALLOIMMUNE THROMBOCYTOPENIA (NAIT), POST-TRANSFUSION PURPURA), GENE ANALYSIS, COMMON VARIANT (EG, HPA-5A/B (K505E))	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81110	HUMAN PLATELET ANTIGEN 6 GENOTYPING (HPA-6W), ITGB3 (INTEGRIN, BETA 3 (PLATELET GLYCOPROTEIN IIIA, ANTIGEN CD61) (GPIIIA) (EG, NEONATAL ALLOIMMUNE THROMBOCYTOPENIA (NAIT), POST-TRANSFUSION PURPURA), GENE ANALYSIS, COMMON VARIANT, HPA-6A/B (R489Q)	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81111	HUMAN PLATELET ANTIGEN 9 GENOTYPING (HPA-9W), ITGA2B (INTEGRIN, ALPHA 2B (PLATELET GLYCOPROTEIN IIB OF IIB/IIIA COMPLEX, ANTIGEN CD41) (GPIIB) (EG, NEONATAL ALLOIMMUNE THROMBOCYTOPENIA (NAIT),POST-TRANSFUSION PUPURA), GENE ANALYSIS, COMMON VARIANT, HPA-9A/B (V837M)	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81112	HUMAN PLATELET ANTIGEN 15 GENOTYPING (HPA-15), CD109 (CD109 MOLECULE) (EG, NEONATAL ALLOIMMUNE THROMBOCYTOPENIA (NAIT), POST-TRANSFUSION PURPURA), GENE ANALYSIS, COMMON VARIANT, HPA-15A/B (S682Y)	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81120	IDH1 (ISOCITRATE DEHYDROGENASE 1 (NADP+), SOLUBLE) (EG, GLIOMA), COMMON VARIANTS (EG, R132H, R132C)	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81121	IDH2 (ISOCITRATE DEHYDROGENASE 2 (NADP+), MITOCHONDRIAL) (EG, GLIOMA), COMMON VARIANTS (EG, R140, R172M)	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81162	BRCA1, BRCA2 (BREAST CANCER 1 AND 2) (EG, HEREDITARY BREAST AND OVARIAN CANCER) GENE ANALYSIS; FULL SEQUENCE ANALYSIS AND FULL DUPLICATION/DELETION ANALYSIS)	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81163	BRCA1, (BRCA1, DNA REPAIR ASSOCIATED), BRCA2 (BRCA2, DNA REPAIR ASSOCIATED) (EG, HEREDITARY BREAST AND OVARIAN CANCER) GENE ANALYSIS;FULL SEQUENCE ANALYSIS	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81165	BRCA1 (BRCA1, DNA REPAIR ASSOCIATED) (EG, HEREDITARY BREAST AND OVARIAN CANCER) GENE ANALYSIS; FULL SEQUENCE ANALYSIS	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81166	BRCA1 (BRCA1, DNA REPAIR ASSOCIATED) (EG, HEREDITARY BREAST AND OVARIAN CANCER) GENE ANALYSIS; FULL DUPLICATION/DELETION ANALYSIS (IE, DETECTION OF LARGE GENE REARRANGEMENTS)	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81167	BRCA2 (BRCA2, DNA REPAIR ASSOCIATED) (EG, HEREDITARY BREAST AND OVARIAN CANCER) GENE ANALYSIS; FULL DUPLICATION/DELETION ANALYSIS (IE, DETECTION OF LARGE GENE REARRANGEMENTS)	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	

Codes	Code Description	Medical Mutual Commercial	Medical Mutual Commercial Criteria	Medicare Advantage	Medicare Advantage Criteria	Details/Notes
81168	CCND1/IGH (T(11;14)) (EG, MANTLE CELL LYMPHOMA) TRANSLOCATION ANALYSIS, MAJOR BREAKPOINT, QUALITATIVE AND QUANTITATIVE, IF PERFORMED	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81170	ABL1 (ABL PROTO-ONCOGENE 1, NON-RECEPTOR TYROSINE KINASE) (EG, ACQUIRED IMATINIB TYROSINE KINASE INHIBITOR RESISTANCE), GENE ANALYSIS, VARIANTS IN THE KINASE DOMAIN	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81171	ABL1 (ABL PROTO-ONCOGENE 1, NON-RECEPTOR TYROSINE KINASE) (EG, ACQUIRED IMATINIB TYROSINE KINASE INHIBITOR RESISTANCE), FULL GENE SEQUENCE	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81172	AFF2 (AF4/FMR2 FAMILY, MEMBER 2 (FMR2) (EG, FRAGILE X MENTAL RETARDATION 2 (FRAXE) GENE ANALYSIS; CHARACTERIZATION OF ALLELES (EG, EXPANDED SIZE AND METHYLATION STATUS)	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81173	AFF2 (AF4/FMR2 FAMILY, MEMBER 2 (FMR2) (EG, FRAGILE X MENTAL RETARDATION 2 (FRAXE) GENE ANALYSIS; FULL GENE SEQUENCE	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81174	ABL1 (ABL PROTO-ONCOGENE 1, NON-RECEPTOR TYROSINE KINASE) (EG, ACQUIRED IMATINIB TYROSINE KINASE INHIBITOR RESISTANCE), KNOWN FAMILIAL VARIANT	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81176	ASXL1 (ADDITIONAL SEX COMBS LIKE 1, TRASCRIPTIONAL REGULATOR) (EG, MYELODYSPLASTIC SYNDROME, MYELOPROLIFERATIVE NEOPLASMS, CHRONIC MYELOMONOCYTIC LEUKEMIA), GENE ANALYSIS; TARGETED SEQUENCE ANALYSIS (EG, EXON 12)	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81177	ATN1 (ATROPHIN 1) (EG, DENTATORUBRAL-PALLIDOLUYSIAN ATROPHY) GENE ANALYSIS, EVALUATION TO DETECT ABNORMAL (EG, EXPANDED) ALLELES	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81178	ATXN1 (ATAXIN 1) (EG, SPINOCEREBELLAR ATAXIA) GENE ANALYSIS, EVALUATION TO DETECT ABNORMAL (EG, EXPANDED) ALLELES	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81179	ATXN2 (ATAXIN 2) (EG, SPINOCEREBELLAR ATAXIA) GENE ANALYSIS, EVALUATION TO DETECT ABNORMAL (EG, EXPANDED) ALLELES	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81180	ATXN3 (ATAXIN 3) (EG, SPINOCEREBELLAR ATAXIA, MACHADO-JOSEPH DISEASE) GENE ANALYSIS, EVALUATION TO DETECT ABNORMAL (EG, EXPANDED) ALLELES	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81181	ATXN7 (ATAXIN 7) (EG, SPINOCEREBELLAR ATAXIA) GENE ANALYSIS, EVALUATION TO DETECT ABNORMAL (EG, EXPANDED) ALLELES	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81182	ATXN8OS (ATXN8 OPPOSITE STRAND (NON-PROTEIN CODING) (EG, SPINOCEREBELLAR ATAXIA) GENE ANALYSIS, EVALUATION TO DETECT ABNORMAL (EG, EXPANDED) ALLELES	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81183	ATXN10 (ATAXIN 10) (EG, SPINOCEREBELLAR ATAXIA) GENE ANALYSIS, EVALUATION TO DETECT ABNORMAL (EG, EXPANDED) ALLELES	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81184	CACNA1A (CALCIUM VOLTAGE-GATED CHANNEL SUBUNIT ALPHA1A) (EG, SPINOCEREBELLAR ATAXIA) GENE ANALYSIS; EVALUATION TO DETECT ABNORMAL (EG, EXPANDED) ALLELES	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81186	CACNA1A (CALCIUM VOLTAGE-GATED CHANNEL SUBUNIT ALPHA1A) (EG, SPINOCEREBELLAR ATAXIA) GENE ANALYSIS; KNOWN FAMILIAL VARIANT	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81187	CNBP (CCHC-TYPE ZINC FINGER NUCLEIC ACID BINDING PROTEIN) (EG, MYOTONIC DYSTROPHY TYPE 2) GENE ANALYSIS, EVALUATION TO DETECT ABNORMAL (EG, EXPANDED) ALLELES	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81188	CSTB (CYSTATIN B) (EG, UNVERRICHT-LUNDBORG DISEASE) GENE ANALYSIS; EVALUATION TO DETECT ABNORMAL (EG, EXPANDED) ALLELES	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81189	CSTB (CYSTATIN B) (EG, UNVERRICHT-LUNDBORG DISEASE) GENE ANALYSIS; FULL GENE SEQUENCE	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81190	CSTB (CYSTATIN B) (EG, UNVERRICHT-LUNDBORG DISEASE) GENE ANALYSIS; KNOWN FAMILIAL VARIANT(S)	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81201	APC (ADENOMATOUS POLYPOSIS COLI)(EG, FAMILIAL ADENOMATOSIS POLYPOSISFAP, ATTENUATED FAP) GENE ANALYSIS; FULL GENE SEQUENCE	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81202	APC (ADENOMATOUS POLPOSIS COLI)(EG, FAMILIAL ADENOMATOSIS POLYPOSIS POLYPOSIS FAP, ATTENUATED FAP) GENE ANALYSIS; KNOWN FAMILIAL VARIANTS	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81203	APC (ADENOMATOUS POLYPOSIS COLI)(EG, FAMILIAL ADENOMATOSIS POLYPOSISFAP, ATTENUATED FAP) GENE ANALYSIS; DUPLICATION/DELETION VARIANTS	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81204	AR (ANDROGEN RECEPTOR) (EG, SPINAL AND BULBAR MUSCULAR ATROPHY, KENNEDY DISEASE, X CHROMOSOME INACTIVATION) GENE ANALYSIS; CHARACTERIZATION OF ALLELES (EG, EXPANDED SIZE OR METHYLATION STATUS)	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	

Codes	Code Description	Medical Mutual Commercial	Medical Mutual Commercial Criteria	Medicare Advantage	Medicare Advantage Criteria	Details/Notes
81206	BCR/ABL1 (T(9;22)) (EG, CHRONIC MYELOGENOUS LEUKEMIA) TRANSLOCATION ANALYSIS; MAJOR BREAKPOINT, QUALITATIVE OR QUANTITATIVE	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81207	BCR/ABL1 (T(9;22)) (EG, CHRONIC MYELOGENOUS LEUKEMIA) TRANSLOCATION ANALYSIS; MINOR BREAKPOINT, QUALITATIVE OR QUANTITATIVE	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81208	BCR/ABL1 (T(9;22)) (EG, CHRONIC MYELOGENOUS LEUKEMIA) TRANSLOCATION ANALYSIS; OTHER BREAKPOINT, QUALITATIVE OR QUANTITATIVE	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81210	BRAF (RAF PROTO-ONCOGENE SERINE/THREONINE KINASE)(EG, COLON CANCER ,MELANOMA), GENE ANALYSIS, V600E VARIANT (S);	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81212	BRCA1, BRCA2 (BREAST CANCER 1 AND 2) (EG, HEREDITARY BREAST AND OVARIAN CANCER) GENE ANALYSIS;185DELAG, 5385INSC, 6174DELT VARIANTS	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81215	BRAC 1 (BREAST CANCER 1)(EG, HEREDITARY BREAST AND OVARIAN CANCER) GENE ANALYSIS; KNOWN FAMILIAL VARIANT	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81216	BRAC2 (BREAST CANCER 2)(EG, HEREDITARY BREAST AND OVARIAN CANCER) GENE ANALYSIS; FULL SEQUENCE ANALYSIS	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81217	BRAC2 (BREAST CANCER 2)(EG, HEREDITARY BREAST AND OVARIAN CANCER) GENE ANALYSIS; KNOWN FAMILIAL VARIANT	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81218	CEBPA (CCAAT/ENHANCE BINDING PROTEIN (C/EBP), ALPHA) (EG, ACUTE MYELOID LEUKEMIA), GENE ANALYSIS, FULL GENE SEQUENCE	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81219	CALR (CALRETICULIN) (EG, MYELOPROLIFERATIVE DISORDERS), GENE ANALYSIS, COMMON VARIANTS IN EXON 9	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81221	CFTR (CYSTIC FIBROSIS TRASMEMBRANE CONDUCTANCE REGULATOR)(EG, CYSTIC FIBROSIS) GENE ANALYSIS; KNOWN FAMILIAL VARIANTS	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81222	CFTR (CYSTIC FIBROSIS TRASMEMBRANE CONDUCTANCE REGULATOR)(EG, CYSTIC FIBROSIS) GENE ANALYSIS; DUPLICATION/DELETION VARIANTS	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81223	CFTR (CYSTIC FIBROSIS TRASMEMBRANE CONDUCTANCE REGULATOR)(EG, CYSTIC FIBROSIS) GENE ANALYSIS; FULL GENE SEQUENCE	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81224	CFTR (CYSTIC FIBROSIS TRASMEMBRANE CONDUCTANCE REGULATOR)(EG, CYSTIC FIBROSIS) GENE ANALYSIS; INTRON 8 POLY\T ANALYSIS (EG, MALE INFERTILITY)	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81225	CYP2C19 (CYTOCHROME P450, FAMILY 2, SUBFAMILY C, POLYPEPTIDE 19) (EG, DRUG METABOLISM), GENE ANALYSIS, COMMON VARIANTS (EG, *2, *3, *4, *8, *17)	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81226	CYP2D6 (CYTOCHROME P450, FAMILY 2, SUBFAMILY D, POLYPEPTIDE 6)(EG, DRUG METABOLISM), GENE ANALYSIS, COMMON VARIANTS (EG, *2, *3, *4, *5, *6, *9, *10, *17, *19, *29, *35, *41, *1XN, *2XN, *4XN)	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81227	CYP2C9 (CYTOCHROME P450, FAMILY 2, SUBFAMILY C, POLYPEPTIDE 9)(EG, DRUG METABOLISM), GENE ANALYSIS, COMMON VARIANTS (*2, *3, *5, *6)	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81228	CYTOGENOMIC CONSTITUTIONAL (GENOME\WIDE) MICROARRAY ANLYSIS; INTERROGATION OF GENOMIC REGIONS FOR COPY NUMBER VARIANTS (EG, BACTERIAL ARTIFICIAL CHROMOSOME (BAC) OR OLIGO\BASED COMPARATIVE GENOMIC HYBRIDIZATION (CGH) MICROARRAY ANALYSIS)	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81229	CYTOGENOMIC CONSTITUTIONAL (GENOME\WIDE) MICROARRAY ANLYSIS; INTERROGATION OF GENOMIC REGIONS FOR COPY NUMBER AND SINGLE NUCLEOTIDE POLYMORPHISM (SNP) VARIANTS FOR CHROMOSOMAL ABNORMALITIES	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81230	CYP3A4 (CYTOCHROME P450, FAMILY 3, SUBFAMILY A MEMBER 4) (EG, DRUG METABOLISM), GENE ANALYSIS, COMMON VARIANT(S) (*2, *22)	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81231	CYP3A5 (CYTOCHROME P450, FAMILY 3, SUBFAMILY A MEMBER 5) (EG,DRUG METABOLISM), GENE ANALYSIS, COMMON VARIANTS (EG, *2, *3, *4, *5, *6, *7)	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81232	DPYD (DIHYDROPYRIMIDINE DEHYDROGENASE) (EG, 5-FLUOROURACIL/5-FU AND CAPECITABINE DRUG METABOLISM), GENE ANALYSIS, COMMON VARIANT(S) (EG, *2A, *4, *5, *6)	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81233	BTK (BRUTON'S TYROSINE KINASE) (EG, CHRONIC LYMPHOCYTIC LEUKEMIA) GENE ANALYSIS, COMMON VARIANTS (EG, C481S, C481R, C481F)	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81234	DMPK (DM1 PROTEIN KINASE)(EG, MYOTONIC DYSTROPHY TYPE 1) GENE ANALYSIS; EVALUATION TO DETECT ABNORMAL (EXPANDED) ALLELES	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81235	EGFR (EPIDERMAL GROWTH FACTOR RECEPTOR)(EG, NON\SMALL CELL LUNG CANCER) GENE ANALYSIS, COMMON VARIANTS (EG, EXON 19 LREA DELETION, L858R, T790M, G719A, G719S, L861Q)	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	

Codes	Code Description	Medical Mutual Commercial	Medical Mutual Commercial Criteria	Medicare Advantage	Medicare Advantage Criteria	Details/Notes
81236	EZH2 (ENHANCER OF ZESTE 2 POLYCOMB REPRESSIVE COMPLEX 2 SUBUNIT) (EG, MYELODYSPLASTIC SYNDROME, MYELOPROLIFERATIVE NEOPLASMS) GENE ANALYSIS, FULL GENE SEQUENCE	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81237	EZH2 (ENHANCER OF ZESTE 2 POLYCOMB REPRESSIVE COMPLEX 2 SUBUNIT) (EG, DIFFUSE LARGE B-CELL LYMPHOMA) GENE ANALYSIS, COMMON VARIANT(S) (EG, CODON 646)	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81238	F9 (COAGULATION FACTOR IX)(EG, HEMOPHILIA B), FULL GENE SEQUENCE	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81239	DMPK (DM1 PROTEIN KINASE)(EG, MYOTONIC DYSTROPHY TYPE 1) GENE ANALYSIS; CHARACTERIZATION OF ALLELES (EG, EXPANDED SIZE)	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81240	F2 (PROTHROMBIN, COAGULATION FACTOR II)(HEREDITARY HYPERCOAGULABILITY) GENE ANALYSIS, 20210G>A VARIANT	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81241	F5 (COAGULATION FACTOR V)(EG, HEREDITARY HYPERCOAGULABILITY) GENE ANALYSIS, LEIDEN VARIANT	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81242	FANCC (FANCONI ANEMIA, COMPLEMENTATION GROUP C)(EG, FANCONI ANEMIA, TYPE C) GENE ANALYSIS, COMMON VARIANT (EG, IVS4+4A>T)	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81243	FMR1 (FRAGILE X MENTAL RETARDATION 1)(EG, FRAGILE X MENTAL RETARDATION) GENE ANALYSIS; EVALUATION TO DETECT ABNORMAL (EG, EXPANDED) ALLELES	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81244	FMR1 (FRAGILE X MENTAL RETARDATION 1)(EG, FRAGILE X MENTAL RETARDATION) GENE ANALYSIS; CHARACTERIZATION OF ALLELES (EG, EXPANDED SIZE AND METHYLATION STATUS)	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81245	FLT3 (FMS\RELATED TYROSINE KINASE 3)(EG, ACUTE MYELOID LEUKEMIA), GENE ANALYSIS, INTERNAL TANDEM DUPLICATION (ITD) VARIANTS (IE, EXONS 14, 15)	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81246	FLT3 (FMS\RELATED TYROSINE KINASE 3)(EG, ACUTE MYELOID LEUKEMIA), GENE ANALYSIS; TYROSINE KINASE DOMAIN (TKD) VARIANTS (EG, D835, I836)	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81247	G6PD (GLUCOSE-6-PHOSPHATE DEHYDROGENASE) (EG, HEMOLYTIC ANEMIA, JAUNDICE), GENE ANALYSIS; COMMON VARIANT(S) (EG, A, A-)	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81248	G6PD (GLUCOSE-6-PHOSPHATE DEHYDROGENASE) (EG, HEMOLYTIC ANEMIA, JAUNDICE), GENE ANALYSIS; KNOWN FAMILIAL VARIANT(S)	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81249	G6PD (GLUCOSE-6-PHOSPHATE DEHYDROGENASE)(EG, HEMOLYTIC ANEMIA, JAUNDICE), GENE ANALYSIS; FULL GENE SEQUENCE	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81250	G6PC (GLUCOSE\6\PHOSPHATASE, CATALYTIC SUBUNIT)(EG, GLYCOGEN STORAGE DISEASE, TYPE 1A, VON GIERKE DISEASE) GENE ANALYSIS, COMMON VARIANTS (EG,R83C, Q347X)	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81251	GBA (GLUCOSIDASE, BETA, ACID)(EG, GAUCHER DISEASE) GENE ANALYSIS, COMMON VARIANTS (EG, N370S, 84GG, L444P, IVS2+1G>A)	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81252	GJB2 (GAP JUNCTION PROTEIN, BETA 2, 26KDA; CONNEXIN 26)(EG, NON\ SYNDROMIC HEARING LOSS) GENE ANALYSIS; FULL GENE SEQUENCE	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81253	GJB2 (GAP JUNCTION PROTEIN, BETA 2, 26KDA; CONNEXIN26)(EG, NON\ SYNDROMIC HEARING LOSS) GENE ANALYSIS; KNOWN FAMILIAL VARIANTS	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81254	GJB6 (GAP JUNCTION PROTEIN, BETA 6, 30KDA, CONNEXIN 30)(EG, NON\ SYNDROMIC HEARING LOSS) GENE ANALYSIS, COMMON VARIANTS (EG, 309KB, DELGJB6\D13S1830) AND 232KB (DELGJB6\D13S1854)	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81255	HEXA (HEXOSAMINIDASE A (ALPHA POLYPEPTIDE))(EG, TAY\SACHS DISEASE) GENE ANALYSIS, COMMON VARIANTS (EG, 1278INSTATC, 1421+1G>C, G269S)	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81256	HFE (HEMOCHROMATOSIS)(EG, HEREDITARY HEMOCHROMATOSIS) GENE ANALYSIS, COMMON VARIANTS (EG, C282Y, H63D)	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
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 ASIA, THAI, FILIPINO, MEDITERRANEAN, ALPHA3.7, ALPHA4.2, ALPHA20.5, AND CONSTANT SPRING)	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81258	HBA1/HBA2 (ALPHA GLOBIN 1 AND ALPHA GLOBIN 2)(EG, ALPHA THALASSEMIA, HB BART HYDROPS FETALIS SYNDROME, HBH DISEASE), GENE ANALYSIS; KNOWN FAMILIAL VARIANT	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81259	HBA1/HBA2 (ALPHA GLOBIN 1 AND ALPHA GLOBIN 2)(EG, ALPHA THALASSEMIA, HB BART HYDROPS FETALIS SYNDROME, HBH DISEASE), GENE ANALYSIS; FULL GENE SEQUENCE	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81260	IKBKAP (INHIBITOR OF KAPPA LIGHT POLYPEPTIDE GENE ENHANCER IN B\CELL KINASE COMPLEX\ASSOCIATED PROTEIN)(EG, FAMILIAL DYAUTONOMIA) GENE ANALYSIS, COMMON VARIANTS (EG, 2507+6T>C, R696P)	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	

Codes	Code Description	Medical Mutual Commercial	Medical Mutual Commercial Criteria	Medicare Advantage	Medicare Advantage Criteria	Details/Notes
81261	IGH@ (IMMUNOGLOBULIN HEAVY CHAIN LOCUS)(EG, LEUKEMIAS AND LYMPHOMAS, B\CELL), GENE REARRANGEMENT ANALYSIS TO DETECT ABNORMAL CLONAL POPULATION(S); AMPLIFIED METHODOLOGY (EG, POLYMERASE CHAIN REACTION)	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81262	IGH@ (IMMUNOGLOBULIN HEAVY CHAIN LOCUS)(EG, LEUKEMIAS AND LYMPHOMAS, B CELL), GENE REARRANGEMENT ANALYSIS TO DETECT ABNORMAL CLONAL POPULATION(S); DIRECT METHODOLOGY (EG, SOUTHERN BLOT)	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81263	IGH@ (IMMUNOGLOBULIN HEAVY CHAIN LOCUS)(EG, LEUKEMIAS AND LYMPHOMAS, B CELL), VARIABLE REGION SOMATIC MUTATION ANALYSIS	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81264	IGK@ (IMMUNOGLOBULIN KAPPA LIGHT CHAIN LOCUS)(EG, LEUKEMIA AND LYMPHOMA, B\CELL), GENE REARRANGEMENT ANALYSIS, EVALUATION TO DETECT ABNORMAL CLONAL POPULATION(S)	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81265	COMPARATIVE ANALYSIS USING SHORT TANDEM REPEAT (STR) MARKERS; PATIENT AND COMPARATIVE SPECIMEN (EG, PRE\TRANSPLANT RECIPIENT AND DONOR GERMLINE TESTING, POST\TRASPLANT 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 REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
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 REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81267	CHIMERISM (ENGRAFTMENT) ANALYSIS, POST TRANSPLANTATION SPECIMEN (EG, HEMATOPOIETIC STEM CELL), INCLUDES COMPARISON TO PREVIOUSLY PERFORMED BASELINE ANALYSES; WITHOUT CELL SELECTION	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
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 REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81269	HBA1/HBA2 (ALPHA GLOBIN 1 AND ALPHA GLOBIN 2)(EG, ALPHA THALASSEMIA, HB BART HYDROPS FETALIS SYNDROME, HBH DISEASE), GENE ANALYSIS; DUPLICATION/DELETION VARIANTS	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81270	JAK2 (JANUS KINASE 2) (EG, MYELOPROLIFERATIVE DISORDER) GENE ANALYSIS, P.VAL617PHE (V617F) VARIANT	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81271	HTT (HUNTINGTIN) (EG, HUNTINGTON DISEASE) GENE ANALYSIS; EVALUATION TO DETECT ABNORMAL (EG, EXPANDED) ALLELES	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81272	KIT (V-KIT HARDY-ZUCKERMAN 4 FELINE SARCOMA VIRAL ONCOGENE HOMOLOG) (EG, GASTROINTESTINAL STROMAL TUMOR (GIST), ACUTE MYELOID LEUKEMIA, MELANOMA), GENE ANALYSIS, TARGETED SEQUENCE ANALYSIS (EG, EXONS 8, 11, 13, 17, 18)	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81273	KIT (V-KIT HARDY-ZUCKERMAN 4 FELINE SARCOMA VIRAL ONCOGENE HOMOLOG) (EG, MASTOCYTOSIS), GENE ANALYSIS, DB16 VARIANT(S)	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81274	HTT (HUNTINGTIN) (EG, HUNTINGTON DISEASE) GENE ANALYSIS; CHARACTERIZATION OF ALLELES (EG, EXPANDED SIZE)	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81275	KRAS (KIRSTEN RAT SARCOMA VIRAL ONCOGENE HOMOLOG)(EG, CARCINOMA) GENE ANALYSIS, VARIANTS IN EXON 2 (EG, CODONS 12 AND 13)	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81276	KRAS (KIRSTEN RAT SARCOMA VIRAL ONCOGENE HOMOLOG)(EG, CARCINOMA) GENE ANALYSIS; VARIANTS IN EXON 2, ADDITIONAL VARIENT(S) (EG, CODON 61, CONDON 146)	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81277	CYTOGENOMIC NEOPLASIA (GENOME-WIDE) MICROARRAY ANALYSIS, INTERROGATION OF GENOMIC REGIONS FOR COPY NUMBER AND LOSS-OF-HETEROZYGOSITY VARIANTS FOR CHROMOSOMAL ABNORMALITIES	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81278	IGH@/BCL2 (T(14;18)) (EG, FOLLICULAR LYMPHOMA) TRANSLOCATION ANALYSIS, MAJOR BREAKPOINT REGION (MBR) AND MINOR CLUSTER REGION (MCR) BREAKPOINTS, QUALITAIVE OR QUANTITATIVE	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81279	JAK2 (JANUS KINASE 2) (EG, MYELOPROLIFERATIVE DISORDER) TARGETED SEQUENCE ANALYSIS (EG, EXONS 12 AND 13)	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81283	IFNL3 (INTERFERON, LAMBDA 3) (EG, DRUG RESPONSE), GENE ANALYSIS, RS12979860 VARIANT	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	

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81284	FXN (FRATAXIN) (EG, FRIEDREICH ATAXIA) GENE ANALYSIS; EVALUATION TO DETECT ABNORMAL (EXPANDED) ALLELES	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81285	FXN (FRATAXIN) (EG, FRIEDREICH ATAXIA) GENE ANALYSIS; CHARACTERIZATION OF ALLELES (EG, EXPANDED SIZE)	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81286	FXN (FRATAXIN) (EG, FRIEDREICH ATAXIA) GENE ANALYSIS; FULL GENE SEQUENCE	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81287	MGMT (O-6-METHYLGUANINE-DNA METHYLTRANSFERASE) (EG, GLIOBLASTOMA MULTIFORME), METHYLATION ANALYSIS	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	CMP201303	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81288	MLH1 (MUTL HOMOLOG 1, COLON CANCER, NONPOLYPOSIS TYPE 2)(EG, HEREDITARY NONPOLYPOSIS COLORECTAL CANCER, LYNCH SYNDROME) GENE ANALYSIS; PROMOTER METHYLATION ANALYSIS	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81289	FXN (FRATAXIN) (EG, FRIEDREICH ATAXIA) GENE ANALYSIS; KNOWN FAMILIAL VARIANT(S)	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81290	MCOLN1 (MUCOLIPIN 1)(EG, MUCOLIPIDOSIS, TYPE IV) GENE ANALYSIS, COMMON VARIANTS (EG, IVS3\2A>G, DEL6.4KB)	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81291	MTHFR (5,10\METHYLENETETRAHYDROFOLATE REDUCTASE)(EG, HEREDITARY HYPERCOAGULABILITY) GENE ANALYSIS, COMMON VARIANTS (EG, 677T, 1298C)	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81292	MLH1 (MUTL HOMOLOG 1, COLON CANCER, NONPOLYPOSIS TYPE 2) (EG, HEREDITARY NON\POLYPOSIS COLORECTAL CANCER, LYNCH SYNDROME) GENE ANALYSIS; FULL SEQUENCE ANALYSIS	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81293	MLH1 (MUTL HOMOLOG 1, COLON CANCER, NONPOLYPOSIS TYPE 2) (EG, HEREDITARY NON\POLYPOSIS COLORECTAL CANCER, LYNCH SYNDROME) GENE ANALYSIS; KNOWN FAMILIAL VARIANTS	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81294	MLH1 (MUTL HOMOLOG 1, COLON CANCER, NONPOLYPOSIS TYPE 2) (EG, HEREDITARY NON\POLYPOSIS COLORECTAL CANCER, LYNCH SYNDROME) GENE ANALYSIS; DUPLICATION/DELETION VARIANTS	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81295	MSH2 (MUTS HOMOLOG 2, COLON CANCER, NONPOLYPOSIS TYPE 1) (EG, HEREDITARY NON\POLYPOSIS COLORECTAL CANCER, LYNCH SYNDROME) GENE ANALYSIS; FULL SEQUENCE ANALYSIS	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81296	MSH2 (MUTS HOMOLOG 2, COLON CANCER, NONPOLYPOSIS TYPE 1) (EG, HEREDITARY NON\POLYPOSIS COLORECTAL CANCER, LYNCH SYNDROME) GENE ANALYSIS; KNOWN FAMILIAL VARIANTS	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81297	MSH2 (MUTS HOMOLOG 2, COLON CANCER, NONPOLYPOSIS TYPE 1) (EG, HEREDITARY NON\POLYPOSIS COLORECTAL CANCER, LYNCH SYNDROME) GENE ANALYSIS; DUPLICATION/DELETION VARIANTS	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81298	MSH6 (MUTS HOMOLOG 6 (E. COLI))(EG, HEREDITARY NON\POLYPOSIS COLORECTAL CANCER, LYNCH SYNDROME) GENE ANALYSIS; FULL SEQUENCE ANALYSIS	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81299	MSH6 (MUTS HOMOLOG 6 (E. COLI))(EG, HEREDITARY NON\POLYPOSIS COLORECTAL CANCER, LYNCH SYNDROME) GENE ANALYSIS; KNOWN FAMILIAL VARIANTS	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81300	MSH6 (MUTS HOMOLOG 6 (E. COLI))(EG, HEREDITARY NON\POLYPOSIS COLORECTAL CANCER, LYNCH SYNDROME) GENE ANALYSIS; DUPLICATION/ DELETION VARIANTS	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81301	MICROSATELLITE INSTABILITY ANALYSIS (EG, HEREDITARY NON\POLYPOSIS COLORECTAL CANCER, LYNCH SYNDROME) OF MARKERS FOR MISMATCH REPAIR DEFICIENCY (EG, BAT25, BAT26), INCLUDES COMPARISON OF NEOPLASTIC AND NORMAL TISSUE, IF PERFORMED	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81304	MECP2 (METHYL CPG BINDING PROTEIN 2)(EG, RETT SYNDROME) GENE ANALYSIS; DUPLICATION/DELETION VARIANTS	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81305	MYD88 (MYELOID DIFFERENTIATION PRIMARY RESPONSE 88) (EG, WALDENSTROM'S MACROGLOBULINEMIA, LYMPHOPLASMACYTIC LEUKEMIA) GENE ANALYSIS, p.Leu265Pro(L265P) VARIANT	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81306	NUDT15 (NUDIX HYDROLASE 15) (EG, DRUG METABOLISM) GENE ANALYSIS, COMMON VARIANT(S) (EG, *2, *3, *4, *5, *6)	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81307	PALB2 (PARTNER AND LOCALIZER OF BRCA2)(EG, BREAST AND PANCREATIC CANCER) GENE ANALYSIS; FULL GENE SEQUENCE	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81308	PALB2 (PARTNER AND LOCALIZER OF BRCA2)(EG, BREAST AND PANCREATIC CANCER) GENE ANALYSIS; KNOWN FAMILIAR VARIANT	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	

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81309	PIK3CA (PHOSPHATIDYLINOSITOL-4, BIPHOSPHAT 3-KINASE, CATALYTIC SUBUNIT ALPHA)(EG, COLORECTAL ADN BREAST CANCER) GENE ANALYSIS, TARGETED SEQUENCE ANAYLSIS (EG, EXONS 7,9,20)	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81312	PABPN1 (POLY(A) BINDING PROTEIN NUCLEAR 1) (EG, OCULOPHARYNGEAL MUSCULAR DYSTROPHY) GENE ANALYSIS, EVALUATION TO DETECT ABNORMAL (EG, EXPANDED) ALLELES	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81313	PCA3/KLK3 (PROSTATE CANCER ANTIGEN 3, NON PROTEIN CODING/KALLIKREIN RELATED PEPTIDASE 3, PROSTATE SPECIFIC ANTIGEN) RATIO (EG, PROSTATE CANCER)	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81314	PDGFRA (PLATELET-DERIVED GROWTH FACTOR RECEPTOR, ALPHA POLYPEPTIDE) (EG, GASTROINTESTINAL STROMAL TUMOR (GIST), GENE ANALYSIS, TARGETED SEQUENCE ANALYSIS (EG, EXONS 12,18)	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81315	PML/RARALPHA, (T(15;17)), (PROMYELOCYTIC LEUKEMIA/RETINOIC ACID RECEPTOR ALPHA)(EG, PROMYELOCYTIC LEUKEMIA) TRANSLOCATION ANALYSIS; COMMON BREAKPOINTS (EG, INTRON 3 AND INTRON 6), QUALITATIVE OR QUANTITATIVE	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81316	PML/RARALPHA, (T(15;17)), (PROMYELOCYTIC LEUKEMIA/RETINOIC ACID RECEPTOR ALPHA)(EG, PROMYELOCYTIC LEUKEMIA) TRANSLOCATION ANALYSIS; SINGLE BREAKPOINT (EG, INTRON 3, INTRON 6 OR EXON 6) QUALITATIVE OR QUANTITATIVE	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81317	PMS2 (POSTMEIOTIC SEGREGATION INCREASED 2 (S. CEREVISIAE))(EG, HEREDITARY NON\POLYPOSIS COLORECTAL CANCER, LYNCH SYNDROME) GENE ANALYSIS; FULL SEQUENCE ANALYSIS	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81318	PMS2 (POSTMEIOTIC SEGREGATION INCREASED 2 (S. CEREVISIAE))(EG, HEREDITARY NON\POLYPOSIS COLORECTAL CANCER, LYNCH SYNDROME) GENE ANALYSIS; KNOWN FAMILIAL VARIANTS	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81319	PMS2 (POSTMEIOTIC SEGREGATION INCREASED 2 (S. CEREVISIAE))(EG, HEREDITARY NON POLYPOSIS COLORECTAL CANCER, LYNCH SYNDROME) GENE ANALYSIS; DUPLICATION/DELETION VARIANTS	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81320	PLCG2 (PHOSPHOLIPASE C GAMMA 2) (EG, CHRONIC LYMPHOCYTIC LEUKEMIA) GENE ANALYSIS, COMMON VARIANTS (EG, R665W, S707F, L845F)	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81321	PTEN (PHOSPHATE AND TENSIN HOMOLOG)(EG, COWDEN SYNDROME, PTEN HAMARTOMA TUMOR SYNDROME) GENE ANALYSIS; FULL SEQUENCE ANALYSIS	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81322	PTEN (PHOSPHATASE AND TENSIN HOMOLOG)(EG, COWDEN SYNDROME, PTEN HAMARTOMA TUMOR SYNDROME) GENE ANALYSIS; KNOWN FAMILIAL VARIANT	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81323	PTEN (PHOSPHATASE AND TENSIN HOMOLOG)(EG, COWDEN SYNDROME, PTEN HAMARTOMA TUMOR SYNDROME) GENE ANALYSIS; DUPLICATION/DELETION VARIANT	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81324	PMP22 (PERIPHERAL MYELIN PROTEIN 22)(EG, CHARCOT\MARIE\TOOTH, HEREDITARY NEUROPATHY WITH LIABILITY TO PRESSURE PALSIES) GENE ANALYSIS; DUPLICATION/DELETION ANALYSIS	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81325	PMP22 (PERIPHERAL MYELIN PROTEIN 22)(EG, CHARCOT\MARIE\TOOTH, HEREDITARY NEUROPATHY WITH LIABILITY TO PRESSURE PALSIES) GENE ANALYSIS; FULL SEQUENCE ANALYSIS	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81326	PMP22 (PERIPHERAL MYELIN PROTEIN 22)(EG, CHARCOT\MARIE\TOOTH, HEREDITARY NEUROPATHY WITH LIABILITY TO PRESSURE PALSIES) GENE ANALYSIS; KNOWN FAMILIAL VARIANT	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81327	SEPT9 (SEPTIN9) EG, COLORECTAL CANCER) METHYLATION ANALYSIS	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81328	SLCO1B1 (SOLUTE CARRIER ORGANIC ANION TRANSPORTER FAMILY, MEMBER 1B1) (EG, ADVERSE DRUG REACTION), GENE ANALYSIS, COMMON VARIANT(S) (EG, *5)	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81329	SMN1 (SURVIVAL OF MOTOR NEURON 1, TELOMERIC) (EG, SPINAL MUSCULAR ATROPHY) GENE ANALYSIS; DOSAGE/DELETION ANALYSIS (EG, CARRIER TESTING), INCLUDES SMN2 (SURVIVAL OF MOTOR NEURON 2, CENTROMERIC) ANALYSIS, IF PERFORMED	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81330	SMPD1 (SPHINGOMYELIN PHOSPHODIESTERASE 1, ACID LYSOSOMAL)(EG, NIEMANN\PICK DISEASE, TYPE A) GENE ANALYSIS, COMMON VARIANTS (EG, R496L, L302P, FSP330)	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	

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81331	SNRPN/UBE3A (SMALL NUCLEAR RIBONECLEOPROTEIN POLYPEPTIDE N AND UBIQUITIN PROTEIN LIGASE E3A)(EG, PRADER\WILLI SYNDROME AND/OR ANGELMAN SYNDROME), METHYLATION ANALYSIS	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81332	SERPINA1 (SERPIN PEPTIDASE INHIBITOR, CLADE A, ALPHA\1 ANTIPROTEINASE, ANTITRYPSIN, MEMBER 1)(EG, ALPHA\A\ANTITRYPSIN DEFICIENCY), GENE ANALYSIS, COMMON VARIANTS (EG, *S AND *Z)	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81333	TGFBI (TRANSFORMING GROWTH FACTOR BETA-INDUCED) (EG, CORNEAL DYSTROPHY) GENE ANALYSIS, COMMON VARIANTS (EG, R124H, R124C, R124L, R555W, R555Q)	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81334	PMP22 (PERIPHERAL MYELIN PROTEIN 22) (EG, CHARCOT-MARIE-TOOTH, HEREDITARY NEUROPATHY WITH LIABILITY TO PRESSURE PALSIES) GENE ANALYSIS; DUPLICATION/DELETION ANALYSIS	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	A-0791 Myelodysplastic Syndromes (Somatic) - Gene Panels	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81335	TPMT (THIOPURINE S-METHYLTRANSFERASE) (EG, *2, *3)	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81336	SMN1 (SURVIVAL OF MOTOR NEURON 1, TELOMERIC) (EG, SPINAL MUSCULAR ATROPHY) GENE ANALYSIS; FULL GENE SEQUENCE	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81337	SMN1 (SURVIVAL OF MOTOR NEURON 1, TELOMERIC) (EG, SPINAL MUSCULAR ATROPHY) GENE ANALYSIS; KNOWN FAMILIAL SEQUENCE VARIANT(S)	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81338	MPL (MPL PROTO-ONCOGENE, THROMBOPOIETIN RECEPTOR) (EG, MYELOPROLIFERATIVE DISORDER) GENE ANALYSIS; COMMON VARIANTS (EG, W515A, W515K, W515L, W515R)	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81339	MPL (MPL PROTO-ONCOGENE, THROMBOPOIETIN RECEPTOR) (EG, MYELOPROLIFERATIVE DISORDER) GENE ANALYSIS; SEQUENCE ANALYSIS, EXON 10	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81340	TRB@ (T CELL ANTIGEN RECEPTOR, BETA)(EG, LEUKEMIA AND LYMPHOMA) GENE REARRANGEMENT ANALYSIS TO DETECT ABNORMAL CLONAL POPULATION(S); USING AMPLICFICATION METHODOLOGY (EG, POLYMERASE CHAIN REACTION)	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81341	TRB@ (T CELL ANTIGEN RECEPTOR, BETA)(EG, LEUKEMIA AND LYMPHOMA) GENE REARRANGEMENT ANALYSIS TO DETECT ABNORMAL CLONAL POPULATION(S); USING DIRECT PROBE METHODOLOGY (EG, SOUTHERN BLOT)	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81342	TRG@ (T CELL ANTIGEN RECEPTOR, GAMMA)(EG, LEUKEMIA AND LYMPHOMA), GENE REARRANGEMENT ANALYSIS, EVALUATION TO DETECT ABNORMAL CLONAL POPULATION(S)	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81343	PPP2R2B (PROTEIN PHOSPHATASE 2 REGULATORY SUBUNIT Bbeta) (EG, SPINOCEREBELLAR ATAXIA) GENE ANALYSIS, EVALUATION TO DETECT ABNORMAL (EG, EXPANDED) ALLELES	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81344	TBP (TATA BOX BINDING PROTEIN)(EG, SPINOCEREBELLAR ATAXIA) GENE ANALYSIS, EVALUATION TO DETECT ABNORMAL (EG, EXPANDED) ALLELES	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81345	TERT (TELOMERASE REVERSE TRANSCRIPTASE) (EG, THYROID CARCINOMA, GLIOBLASTOMA MULTIFORME) GENE ANALYSIS, TARGETED SEQUENCE ANALYSIS (EG, PROMOTER REGION)	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81346	TYMS (THYMIDYLATE SYNTHETASE) (EG, 5-FLUOROURACIL/5-FU DRUG METABOLISM), GENE ANALYSIS, COMMON VARIANT(S) (EG, TANDEM REPEAT VARIANT)	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81347	SF3B1 (SPLICING FACTOR [3B] SUBUNIT B1) (EG, MYELODYSPLASTIC SYNDROME/ACUTE MYELOID LEUKEMIA) GENE ANALYSIS, COMMON VARIANTS (EG, A672T, E622D, L833F, R625C, R625L)	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81348	SRSF2 (SERINE AND ARGININE-RICH SPLICING FACTOR 2) (EG, MYELODYSPLASTIC SYNDROME, ACUTE MYELOID LEUKEMIA) GENE ANALYSIS, COMMON VARIANTS (EG, P95H, P95L)	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81349	CYTOGENOMIC (GENOME-WIDE) ANALYSIS FOR CONSTITUTIONAL CHROMOSOMAL ABNORMALITIES; INTERROGATION OF GENOMIC REGIONS FOR COPY NUMBER AND LOSS-OF-HETEROZGOSITY VARIANTS, LOW-PASS SEQUENCING ANALYSIS	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81350	UGT1A1 (UDP GLUCURONOSYLTRANSERASE 1 FAMILY, POLYPEPTIDE A1)(EG, DRUG METABOLISM, HEREDITARY UNCONJUGATED HYPERBILIRUBINEMIA [GILBERT SYNDROME}) GENE ANALYSIS, COMMON VARIANTS (EG, *28, *36 *37)	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81351	TP53 (TUMOR PROTEIN 53) (EG, LI-FRAUMENI SYNDROME) GENE ANALYSIS; FULL GENE SEQUENCE	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	

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81352	TP53 (TUMOR PROTEIN 53) (EG, LI-FRAUMENI SYNDROME) GENE ANALYSIS; TARGETED SEQUENCE ANALYSIS (EG, 4 ONCOLOGY)	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81353	TP53 (TUMOR PROTEIN 53) (EG, LI-FRAUMENI SYNDROME) GENE ANALYSIS; KNOWN FAMILIAL VARIANT	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81357	U2AF1 (U2 SMALL NUCLEAR RNA AUXILIARY FACTOR 1) (EG, MYELODYSPLASTIC SYNDROME, ACUTE MYELOID LEUKEMIA) GENE ANALYSIS, COMMON VARIANTS (EG, S34F, S34Y, Q157R, Q157P)	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81361	HBB (HEMOGLOBIN, SUBUNIT BETA) (EG, SICKLE CELL ANEMIA, BETA THALASSEMIA, HEMOGLOBINOPATHY); COMMON VARIANT(S) (EG, HBS, HBC, HBE)	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81362	HBB (HEMOGLOBIN, SUBUNIT BETA) (EG, SICKLE CELL ANEMIA, BETA THALASSEMIA, HEMOGLOBINOPATHY); KNOWN FAMILIAL VARIANT(S)	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81363	HBB (HEMOGLOBIN, SUBUNIT BETA) (EG, SICKLE CELL ANEMIA, BETA THALASSEMIA, HEMOGLOBINOPATHY); DUPLICATION/DELETION VARIANT(S)	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81364	HBB (HEMOGLOBIN, SUBUNIT BETA) (EG, SICKLE CELL ANEMIA, BETA THALASSEMIA, HEMOGLOBINOPATHY); FULL GENE SEQUENCE	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81370	HLA CLASS I AND II TYPING, LOW RESOLUTION (EG, ANTIGEN EQUIVALENTS); HLA\A, \B, \C, \DRB1/3/4/5, AND \DQB1	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81371	HLA CLASS I AND II TYPING, LOW RESOLUTION (EG, ANTIGEN EQUIVALENTS); HLA\A, \B, AND \DRB1 (EG, VERIFICATION TYPING)	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81372	HLA CLASS I TYPING, LOW RESOLUTION (EG, ANTIGEN EQUIVALENTS); COMPLETE (IE, HLA\A, \B, AND \C)	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81373	HLA CLASS I TYPING, LOW RESOLUTION (EG, ANTIGEN EQUIVALENTS); ONE LOCUS (EG, HLA\A, \B, OR \C) EACH	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81374	HLA CLASS I TYPING, LOW RESOLUTION (EG, ANTIGEN EQUIVALENTS); ONE ANTIGEN EQUIVALENT (EG, B*27), EACH	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81375	HLA CLASS II TYPING, LOW RESOLUTION (EG, ANTIGEN EQUIVALENTS); HLA\DRB1/3/4/5 AND \DQB1	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	CMP201303	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
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 REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81377	HLA CLASS II TYPING, LOW RESOLUTION (EG, ANTIGEN EQUIVALENTS); ONE ANTIGEN EQUIVALENT, EACH	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81378	HLA CLASS I AND II TYPING, HIGH RESOLUTION (IE, ALLELES OR ALLELE GROUPS), HLA\A, \B, \C, AND \DRB1	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81379	HLA CLASS I TYPING, HIGH RESOLUTION (IE, ALLELES OR ALLELE GROUPS); COMPLETE (IE, HLA\A, \B, AND \C)	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81380	HLA CLASS I TYPING, HIGH RESOLUTION (IE, ALLELES OR ALLELE GROUPS); ONE LOCUS (EG, HLA\A, \B, OR \C), EACH	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81381	HLA CLASS I TYPING, HIGH RESOLUTION (IE, ALLELES OR ALLELE GROUP); ONE ALLELE OR ALLELE GOUP (EG, B*57:01P), EACH	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81382	HLA CLASS II TYPING, HIGH RESOLUTION (IE, ALLELES OR ALLELE GOUPS); ONE LOCUS (EG, HLA\DRB1, \DRB4,5 \DQB1, \DQA1, \DPB1, OR \DPA1), EACH	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81383	HLA CLASS II TYPING, HIGH RESOLUTION (IE, ALLELES OR ALLELE GOUPS); ONE ALLELE OR ALLELE GROUP (EG, HLA\DQB1*06:02P), EACH	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
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) ... *** DESCRIPTION TOO EXTENSIVE; SEE CODE BOOK FOR COMPLETE INFO ***	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
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) .... *** DESCRIPTION TOO EXTENSIVE; SEE CODE BOOK FOR COMPLETE INFO ***	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
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 1 EXON) *** DESCRIPTION TOO EXTENSIVE, SEE CODE BOOK FOR COMPLETE INFO ***	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	

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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) ... *** DESCRIPTION TOO EXTENSIVE, SEE CODE BOOK FOR COMPLETE INFO ***	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
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) ... *** DESCRIPTION TOO EXTENSIVE; SEE CODE BOOK FOR COMPLETE INFO ***	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
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) *** DESCRIPTION TOO EXTENSIVE; SEE CODE BOOK FOR COMPLETE INFO ***	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81406	MOLECULAR PATHOLOGY PROCEDURE, LEVEL 7 (EG, ANALYSIS OF 11-25 EXONS BY DNA SEQUENCE ANALYSIS, MUTATION SCANNING OR DUPLICATION/DELETION VARIANTS OF 26-50 EXONS, *** DESCRIPTION TOO EXTENSIVE; SEE CODE BOOK FOR FURTHER INFO ***	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
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) APOB (APOLIPOPROTEIN B) (EG, FAMILIAL HYPERCHOLESTEROLEMIA TYPE B) FULL GENE SEQUENCE	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81408	MOLECULAR PATHOLOGY PROCEDURE, LEVEL 9 (EG, ANALYSIS OF >50 EXONS IN A SINGLE GENE BY DNA SEQUENCE ANALYSIS) ... *** DESCRIPTION TOO EXTENSIVE; SEE CODE BOOK FOR COMPLETE INFO ***	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81410	AORTIC DYSFUNCTION OR DILATION (EG, MARFAN SYNDROME, LOEYS DIETZ SYNDROME, EHLER DANLOS SYNDROME TYPE IV, ARTERIAL TORTUOSITY SYNDROME); GENOMIC SEQUENCE ANALYSIS PANEL, MUST INCLUDE SEQUENCING OF AT LEAST 9 GENES, INCLUDING FBN1, TGFBR1, TGFBR2, COL3A1, MYH11, ACTA2, SLC2A10, SMAD3, AND MYLK	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
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 ANLYSES FOR TGFBR1, TGFBR2, COL3A1, MYH11	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81413	CARDIAC ION CHANNELOPATHIES (EG, BRUGADA SYNDROME, LONG QT SYNDROME, SHORT QT SYNDROME, CATECHOLAMINERGIC POLYMORPHIC VENTRICULAR TACHYCARDIA); GENOMIC SEQUENCE ANALYSIS PANEL. (REFER TO 2017 CPT BOOK FOR COMPLETE DESCRIPTION)	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81414	CARDIAC ION CHANNEOPATHIES (EG, BRUGADA SYNDROME, LONG QT SYNDROME, SHORT QT SYNDROME, CATECHOLAMINERGIC POLYMORPHIC VENTRICULAR TACHYCARDIA); DUPLICATION/DELETION GENE ANALYSIS PANEL, MUST INCLUDE ANANLYSIS OF AT LEAST 2 GENES, INCLUDING KCNH2 AND KCNQ1	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81415	EXOME (EG, UNEXPLAINED CONSTITUTIONAL OR HERITABLE DISORDER OR SYNDROME); SEQUENCE ANALYSIS	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81416	EXOME (EG, UNEXPLAINED CONSTITUTIONAL OR HERITABLE DISORDER OR SYNDROME); SEQUENCE ANALYSIS, EACH COMPARATOR EXOME (EG, PARENTS, SIBLINGS)(LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81417	EXOME (EG, UNEXPLAINED CONSTITUTIONAL OR HERITABLE DISORDER OR SYNDROME); RE-EVALUATION OF PREVIOUSLY OBTAINED EXOME SEQUENCE (EG, UPDATED KNOWLEDGE OR UNRELATED CONDITION/SYNDROME)	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81418	DRUG METABOLISM (EG, PHARMACOGENOMICS) GENOMIC SWQUENCE ANALYSIS PANEL, MUST INCLUDE TESTING OF AT LEAST 6 GENES, INCLUDING CYP2C19, CYP2D6, AND CYP2D6 DUPLICATION/ DELETION ANALYSIS	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81419	EPILEPSY GENOMIC SEQUENCE ANALYSIS PANEL, MUST INCLUDE ANALYSES FOR ALDH7A1, CACNA1A, CDKL5, CHD2, GABRG2, GRIN2A, KCNQ2, MECP2, PCDH19, POLG, PRRT2, SCN1A, SCN1B, SCN2A, SCN8A, SLC2A1, SLC9A6, STXBP1, SYNGAP1, TCF4, TPP1, TSC1, TSC2, AND ZEB2	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81422	FETAL CHROMOSOMAL MICRODELETION(S)GENOMIC SEQUENCE ANALYSIS (EG, DIGEORGE SYNDROME, CRI-DU-CHAT SYNDROME), CIRCULATING CELL-FREE FETAL DNA IN MATERNAL BLOOD	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	

Codes	Code Description	Medical Mutual Commercial	Medical Mutual Commercial Criteria	Medicare Advantage	Medicare Advantage Criteria	Details/Notes
81425	GENOME (EG, UNEXPLAINED CONSTITUTIONAL OR HERITABLE DISORDER OR SYNDROME); SEQUENCE ANALYSIS	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81426	GENOME (EG, UNEXPLAINED CONSTITUTIONAL OR HERITABLE DISORDER OR SYNDROME); SEQUENCE ANALYSIS, EACH COMPARATOR GENOME (EG, PARENTS, SIBLINGS)(LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81427	GENOME (EG, UNEXPLAINED CONSTITUTIONAL OR HERITABLE DISORDER OR SYNDROME); RE-EVALUATION OF PREVIOUSLY OBTAINED GENOME SEQUENCE (EG, UPDATED KNOWLEDGE OR UNRELATED CONDITION/SYNDROME)	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81430	HEARING LOSS (EG, NONSYNDROMIC HEARING LOSS, USHER SYNDROME, PENDRED SYNDROME); GENOMIC SEQUENCE ANALYSIS PANEL, MUST INCLUDE SEQUENCING OF AT LEAST 60 GENES, INCLUDING CDH23, CLRN1, GJB2, GPR98, MTRNR1, MYO7A, MYO15A, PCDH15, OTOF, SLC26A4, TMC1, TMPRSS3, USH1C, USH1G, USH2A, AND WES1	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81431	HEARING LOSS (EG, NONSYNDROMIC HEARING LOSS, USHER SYNDROME, PENDRED SYNDROME);DUPLICATION/DELETION ANALYSIS PANEL, MUST INCLUDE COPY NUMBER ANALYSES FOR STRC AND DFNB1 DELETIONS IN GJB2 AND GJB6 GENES	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81432	HEREDITARY BREAST CANCER-RELATED DISORDERS (EG, HEREDITARY BREAST CANCER, HEREDITARY OVARIAN CANCER, HEREDITARY ENDOMETRIAL CANCER); GENOMIC SEQUENCE ANALYSIS PANEL, MUST INCLUDE SEQUENCING OF AT LEAST 10 GENES, ALWAYS INCLUDING BRCA1, BRCA2, CDH1, MLH1, MSH2, MSH6, PALB2, PTEN, STK11, AND TP53	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81433	HEREDITARY BREAST CANCER-RELATED DISORDERS (EG, HEREDITARY BREAST CANCER, HEREDITARY OVARIAN CANCER, HEREDITARY ENDOMETRIAL CANCER; GENOMIC SEQUENCE ANALYSIS PANEL, DUPLICATION/DELETION ANALYSIS PANEL, MUST INCLUDE FOR BRCA1, BRCA2, MLH1, MLH2, AND STK11	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81434	HEREDITARY RETINAL DISORDERS (EG, RETINITIS PIGMENTOSA, LEBER CONGENITAL AMAUROSIS, CONE-ROD DYSTROPHY), GENOMIC SEQUENCE ANALYSIS PANEL, MUST INCLUDE SEQUENCING OF AT LEAST 15 GENES, INCLUDING ABCA4, CNGA1, CRB1, EYS, PDE6A, PDE6B, PRPF31, PRPH2, RDH12, RHO, RP1, RP2, RPE65, RPGR, AND USH2A	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81437	HEREDITARY NEUROENDOCRINE TUMOR DISORDERS (EG, MEDULLARY THYROID CARCINOMA, PARATHYROID CARCINOMA, MALIGNANT PHEOCHROMOCYTOMA OR PARAGANGLIOMA; GENOMIC SEQUENCE ANALYSIS PANEL, MUST INCLUDE SEQUENCING OF AT LEAST 6 GENES, INCLUDING MAX, SDHB, SDHC, SDHD, TMEM127, AND VHL	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	A-0798 Paraganglioma-Pheochromocytoma (Hereditary) - Gene Testing and Gene Panel	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81438	HEREDITARY NEUROENDOCRINE TUMOR DISORDERS (EG, MEDULLARY THYROID CARCINOMA, PARATHYROID CARCINOMA, MALIGNANT PHEOCHROMOCYTOMA OR PARAGANGLIOMA; DUPLICATION/DELETION ANALYSIS PANEL, MUST INCLUDE ANALYSES FOR SDHB, SDHC, SDHD, AND VHL	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	A-0798 Paraganglioma-Pheochromocytoma (Hereditary) - Gene Testing and Gene Panel	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81439	HEREDIATARY CARDIOMYOPATHY (EG, HYPERTROPHIC CARDIOMYOPATHY, DILATED CARDIOMYOPATHY, ARRHYTHMOGENIC RIGHT VENTRICULAR CARDIOMYOPATHY) GENOMIC SEQUENCE ANALYSIS PANEL, MUST INCLUDE SEQUENCING OF AT LEAST 5 CARDIOMYOPATHY-RELATED GENES, (EG, DSG2, MYBPC3, MYH7, PKP2, AND TTN)	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81440	NUCLEAR ENCODED MITOCHONDRIAL GENES (EG, NEUROLOGIC OR MYOPATHIC PHENOTYPES), GENOMIC SEQUENCE PANEL, MUST INCLUDE ANALYSIS OF AT LEAST 100 GENES, INCLUDING BCS1L, C10ORF2, COQ2, COX10, DGUOK, MPV17, OPA1, PDSS2, POLG, POLG2, RRM2B, SCO1, SCO2, SLC25A4, SUCLA2, SUCLG1, TAZ, TK2 AND TYMP	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81441	INHERITED BONE MARROW FAILURE SYNDROMES (IBMFS) (EG, FANCONI ANEMIA, DYSKERATOSIS CONGENITA, DIAMOND-BLACKFAN ANEMIA, SHWACHMAN-DIAMOND SYNDROME, GATA2 DEFICIENCY SYNDROME, CONGENITAL AMEGAKARYOCYTIC THROMBOCYTOPENIA) SEQUENCE ANALYSIS PANEL, MUST INCLUDE SEQUENCING OF AT LEAST 30 GENES, INCLUDING BRCA2, BRIP1, DKC1, FANCA, FANCB, FANCC, FANCD2, FANCE, FANCF, FANCG, FANCI, FANCL, GATA1, GATA2, MPL, NHP2, NOP10, PALB2, RAD51C, RPL11, RPL35A, RPL5, RPS10, RPS19, RPS24, RPS26, RPS7, SBDS, TERT, AND TINF2	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	

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81442	NOONAN SPECTRUM DISORDERS (EG, NOONAN SYNDROME, CARDIO-FACIO-CUTANEOUS SYNDROME, COSTELLO SYNDROME, LEOPARD SYNDROME, NOONAN-LIKE SYNDROME), GENOMIC SEQUENCE ANALYSIS PANEL, MUST INCLUDE SEQUENCING OF AT LEAST 12 GENES, INCLUDING BRAF, CBL, HRAS, KRAS, MAP2K1, MAP2K2, NRAS, PTPN11, RAF1 RIT1, SHOC2, AND SOS1	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81443	GENETIC TESTING FOR SEVERE INHERITED CONDITIONS (EG, CYSTIC FIBROSIS, ASHKENAZI JEWISH-ASSOCIATED DISORDERS (EG, BLOOM SYNDROME, CANAVAN DISEASE, FANCONI ANEMIA TYPE C, MUCOLIPIDOSIS TYPE VI, GAUCHER DISEASE, TAY-SACHS DISEASE, BETA HEMOGLOBINOPATHIES, PHENYLKETONURIA, GALACTOSEMIA), GENOMIC SEQUENCE ANALYSIS PANEL, MUST INCLUDE SEQUENCING OF AT LEAST 15 GENES (REFER TO 2019 CPT BOOK FOR COMPLETE DESCRIPTION)	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81445	TARGETED GENOMIC SEQUENCE ANALYSIS PANEL, SOLID ORGAN NEOPLASM, DNA ANALYSIS, AND RNA ANALYSIS WHEN PERFORMED, 5-50 GENES (EG, ALK, BRAF, CDKN2A, EGFR, ERBB2, KIT, KRAS, NRAS, MET, PDGFRA, PDGFRB, PGR, PIK3CA, PTEN, RET), INTERROGATION FOR SEQUENCE VARIANTS AND COPY NUMBER VARIANTS OR REARRANGEMENTS, IF PERFORMED	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81448	HEREDITARY PERIPHERAL NEUROPATHIES (EG, CHARCOT-MARIE-TOOTH, SPASTIC PARAPLEGIA), GENOMIC SEQUENCE ANALYSIS PANEL, MUST INCLUDE SEQUENCING OF AT LEAST 5 PERIPHERAL NEUROPATHY-RELATED GENES (EG, BSCL2, GJB1, MFN2, MPZ, REEP1, SPAST, SPG11, SPTLC1)	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81449	TARGETED GENOMIC SEQUENCE ANALYSIS PANEL, SOLID ORGAN NEOPLASM, 5-50 GENES (EG, ALK, BRAF, CDKN2A, EGFR, ERBB2, KIT, KRAS, MET, NRAS, PDGFRA, PDGFRB, PGR, PIK3CA, PTEN, RET), INTERROGATION FOR SEQUENCE VARIANTS AND COPY NUMBER VARIANTS OR REARRANGEMENTS, IF PERFORMED; RNA ANALYSIS	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81450	TARGETED GENOMIC SEQUENCE ANALYSIS PANEL, HEMATOLYMPHOID NEOPLASM OR DISORDER, DNA ANALYSIS, AND RNA ANALYSIS WHEN PERFORMED, 5-50 GENES (EG, BRAF, CEBPA, DNMT3A, EZH2, FLT3, IDH1, IDH2, JAK2, KRAS, KIT, MSS, NRAS, NPM1 NOTCH1), INTERROGATION FOR SEQUENCE VARIANTS, AND COPY NUMBER VARIANTS OR REARRANGEMENTS, OR ISOFORM EXPRESSION OR MRNA EXPRESSION LEVELS, IF PERFORMED	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201923	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81451	TARGETED GENOMIC SEQUENCE ANALYSIS PANEL, HEMATOLYMPHOID NEOPLASM OR DISORDER, 5-50 GENES (EG, BRAF, CEBPA, DNMT3A, EZH2, FLT3, IDH1, IDH2, JAK2, KIT, KRAS, MLL, NOTCH1, NPM1, NRAS), INTERROGATION FOR SEQUENCE VARIANTS, AND COPY NUMBER VARIANTS OR REARRANGEMENTS, OR ISOFORM EXPRESSION OR MRNA EXPRESSION LEVELS, IF PERFORMED; RNA ANALYSIS	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81455	TARGETED GENOMIC SEQUENCE ANALYSIS PANEL, SOLID ORGAN OR HEMATOLYMPHOID NEOPLASM, DNA ANALYSIS, AND RNA ANALYSIS WHEN PERFORMED, 51 OR GREATER GENES (EG, ALK, GRAF, CDKN2A, CEBPA, DNMT3A, EGFR, ERBB2, EZH2, FLT3, IDH1, IDH2, JAK2, KIT, KRAS, MLL, NPM1, NRAS, MET, NOTCH1, PDGFRA, PDGFRB, PGR, PIK3CA, PTEN, RET), INTERROGATION FOR SEQUENCE VARIANTS AND COPY NUMBER VARIANTS OR REARRANGEMENTS, IF PERFORMED	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81456	TARGETED GENOMIC SEQUENCE ANALYSIS PANEL, SOLID ORGAN OR HEMATOLYMPHOID NEOPLASM OR DISORDER, 51 OR GREATER GENES (EG, ALK, BRAF, CDKN2A, CEBPA, DNMT3A, EGFR, ERBB2, EZH2, FLT3, IDH1, IDH2, JAK2, KIT, KRAS, MET, MLL, NOTCH1, NPM1, NRAS, PDGFRA, PDGFRB, PGR, PIK3CA, PTEN, RET), INTERROGATION FOR SEQUENCE VARIANTS AND COPY NUMBER VARIANTS OR REARRANGEMENTS, OR ISOFORM EXPRESSION OR MRNA EXPRESSION LEVELS, IF PERFORMED; RNA ANALYSIS	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81457	SOLID ORGAN NEOPLASM, GENOMIC SEQUENCE ANALYSIS PANEL, INTERROGATION FOR SEQUENCE VARIANTS; DNA ANALYSIS, MICROSATELLITE INSTABILITY	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81458	SOLID ORGAN NEOPLASM, GENOMIC SEQUENCE ANALYSIS PANEL, INTERROGATION FOR SEQUENCE VARIANTS; DNA ANALYSIS, COPY NUMBER VARIANTS AND MICROSATELLITE INSTABILITY	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81459	SOLID ORGAN NEOPLASM, GENOMIC SEQUENCE ANALYSIS PANEL, INTERROGATION FOR SEQUENCE VARIANTS; DNA ANALYSIS OR COMBINED DNA AND RNA ANALYSIS, COPY NUMBER VARIANTS, MICROSATELLITE INSTABILITY, TUMOR MUTATION BURDEN, AND REARRANGEMENTS	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	

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81460	WHOLE MITOCHONDRIAL GENOME (EG, LEIGH SYNDROME, MOTOCHONDRIAL ENCEPHALOMYOPATHY, LACTIC ACIDOSIS, AND STROKE-LIKE EPISODES (MELAS), MYOCLONIC EPILEPSY, WITH RAGGED-RED FIBERS (MERFF), NEUROPATHY, ATAXIA, AND RETINITIS PIGMENTOSA (NARP), LEBER HEREDITARY OPTIC NEUROPATHY (LHON), GENOMIC SEQUENCE, MUST INCLUDE SEQUENCE ANALYSIS OF ENTIRE MITOCHONDRIAL GENOME WITH HETEROPLASMY DETECTION	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81462	SOLID ORGAN NEOPLASM, GENOMIC SEQUENCE ANALYSIS PANEL, CELL-FREE NUCLEIC ACID (EG, PLASMA), INTERROGATION FOR SEQUENCE VARIANTS; DNA ANALYSIS OR COMBINED DNA AND RNA ANALYSIS, COPY NUMBER VARIANTS AND REARRANGEMENTS	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81463	SOLID ORGAN NEOPLASM, GENOMIC SEQUENCE ANALYSIS PANEL, CELL-FREE NUCLEIC ACID (EG, PLASMA), INTERROGATION FOR SEQUENCE VARIANTS; DNA ANALYSIS, COPY NUMBER VARIANTS, AND MICROSATELLITE INSTABILITY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81464	SOLID ORGAN NEOPLASM, GENOMIC SEQUENCE ANALYSIS PANEL, CELL-FREE NUCLEIC ACID (EG, PLASMA), INTERROGATION FOR SEQUENCE VARIANTS; DNA ANALYSIS OR COMBINED DNA AND RNA ANALYSIS, COPY NUMBER VARIANTS, MICROSATELLITE INSTABILITY, TUMOR MUTATION BURDEN, AND REARRANGEMENTS	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81465	WHOLE MITOCHONDRIAL GENOME LARGE DELETION ANALYSIS PANEL (EG, KEARNS-SAYRE DYNDROME, CHRONIC PROGRESSIVE EXTERNAL OPHTHALMOPLEGIA), INCLUDING HETEROPLASMY DETECTION, IF PERFORMED	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81470	X-LINKED INTELLECTUAL DISABILITY (XLID) (EG, SYNDROMIC AND NON-SYNDROMIC XLID); GENOMIC SEQUENCE ANALYSIS PANEL, MUST INCLUDE SEQUENCING OF AT LEAST 60 GENES, INCLUDING ARX, ATRX, CDKL5, FGD1, FMR1, HUWE1,+B25:B36 IL1RAPL, KDM5C, L1CAM, MECP2, MED12, MID1, OCRL, RPS6KA3, AND SLC16A2	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81471	X-LINKED INTELLECTUAL DISABILITY (XLID) (EG, SYNDROMIC AND NON-SYNDROMIC XLID); DUPLICATION/DELETION GENE ANALYSIS, MUST INCLUDE ANALYSIS OF AT LEAST 60 GENES, INCLUDING ARX, ATRX, CDKL5, FDG1, FMR1, HUWE1, IL1RAPL, KDM5C, L1CAM, MECP2, MED12, MID1, OCRL, RPS6KA3, AND SLC16A2	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81479	UNLISTED MOLECULAR PATHOLOGY PROCEDURE	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303, CMP201923	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81493	CORONARY ARTERY DISEASE, mRNA, GENE EXPRESSION PROFILING BY REAL-TIME RT-PCR OF 23 GENES, UTILIZING WHOLE PERIPHERAL BLOOD, ALGORITHM REPORTED AS A RISK SCORE	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81504	ONCOLOGY (TISSUE OF ORIGIN), MICROARRAY GENE EXPRESSION PROFILING OF > 2000 GENES, UTILIZING FORMALIN-FIXED PARAFFIN-EMBEDDED TISSUE, ALGORITHM REPORTED AS TISSUE SIMILARITY SCORES	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81506	ENDOCRINOLOGY (TYPE 2 DIABETES), BIOCHEMICAL ASSAYS OF SEVEN ANALYTE(GLUCOSE, HBA1C, INSULIN, HS\CRP, ADOPONECTIN, FERRITIN, INTERLEUKIN 2\RECEPTOR ALPHA), UTILIZING SERUM OR PLASMA, ALGORITHM REPORTING A RISK SCORE	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81507	FETAL ANEUPLOIDY (TRISOMY 21, 18, AND 13) DNA SEQUENCE ANALYSIS OF SELECTED REGIONS USING MATERNAL PLASMA, ALGORITHM REPORTED AS A RISK SCORE FOR EACH TRISOMY	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81517	LIVER DISEASE, ANALYSIS OF 3 BIOMARKERS (HYALURONIC ACID (HA), PROCOLLAGEN III AMINO TERMINAL PEPTIDE (PIIINP), TISSUE INHIBITOR OF METALLOPROTEINASE 1 (TIMP-1)), USING IMMUNOASSAYS, UTILIZING SERUM, PROGNOSTIC ALGORITHM REPORTED AS A RISK SCORE AND RISK OF LIVER FIBROSIS AND LIVER-RELATED CLINICAL EVENTS WITHIN 5 YEARS	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81518	ONCOLOGY (BREAST), MRNA, GENE EXPRESSION PROFILING BY REAL-TIME RT-PCR OF 11 GENES (7 CONTENT AND 4 HOUSEKEEPING), UTILIZING FORMALIN-FIXED PARAFFIN-EMBEDDED TISSUE, ALGORITHMS REPORTED AS PERCENTAGE RISK FOR METASTATIC RECURRENCE AND LIKELIHOOD OF BENEFIT FROM EXTENDED ENDOCRINE THERAPY	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81519	ONCOLOGY (BREAST), MRNA, GENE EXPRESSION PROFILING BY REAL-TIME RT-PCR OF 21 GENES, UTILIZING FORMALIN-FIXED PARAFFIN EMBEDDED TISSUE, ALGORITHM REPORTED AS RECURRENCE SCORE	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	

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81520	ONCOLOGY (BREAST), MRNA GENE EXPRESSION PROFILING BY HYBRID CAPTURE OF 58 GENES (50 CONTENT AND 8 HOUSEKEEPING), UTILIZING FORMALIN-FIXED PARAFFIN-EMBEDDED TISSUE, ALGORITHM REPORTED AS A RECURRENCE RISK SCORE	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81521	Oncology (breast), mRNA, microarray gene expression profiling of 70 content genes and 465 housekeeping genes, utilizing fresh frozen or formalin-fixed paraffin-embedded tissue, algorithm reported as index related to risk of distant metastasis	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81522	ONCOLOGY (BREAST), MRNA, GENE EXPRESSION PROFILING BY RT-PCR OF 12 GENES (8 CONTENT AND 4 HOUSEKEEPING), UTILIZING FORMALIN-FIXED PARAFFIN-EMBEDDED TISSUE, ALGORITHM REPORTED AS RCURRENCE RISK SCORE	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81523	ONCOLOGY (GYNECOLOGIC), LIVE TUMOR CELL CULTURE AND CHEMOTHERAPEUTIC RESPONSE BY DAPI STAIN AND MORPHOLOGY, PREDICTIVE ALGORITHM REPORTED AS A DRUG RESPONSE SCORE; FIRST SINGLE DRUG OR DRUG COMBINATION	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81525	ONCOLOGY (COLON), MRNA, GENE EXPRESSION PROFILING BY REAL-TIME RT-PCR OF 12 GENES (7 CONTENT AND 5 HOUSEKEEPING), UTILIZING FORMALIN-FIXED PARAFFIN-EMBEDDED TISSUE, ALGORITHM REPORTED AS A RECURRENCE SCORE	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81529	ONCOLOGY (CUTANEOUS MELANOMA),mRNA, GENE EXPRESSION PROFILING BY REAL-TIME RT-PCR OF 31 GENES (28 CONTENT AND 3 HOUSEKEEPING), UTILIZING FORMALIN-FIXED PARAFFIN-EMBEDDED TISSUE, ALGORITHM REPORTED AS RECURRENCE RISK, INCLUDING LIKELIHOOD OF SENTINEL LYMPH NODE METASTASIS	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81538	ONCOLOGY (LUNG), MASS SPECTROMETRIC 8-PROTEIN SIGNATURE, INCLUDING AMYLOID A, UTILIZING SERUM, PROGNOSTIC AND PREDICTIVE ALGORITHM REPORTED AS GOOD VERSUS POOR OVERALL SURVIVAL	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81540	ONCOLOGY (TUMOR OF UNKNOWN ORIGIN), MRNA, GENE EXPRESSION PROFILING BY REAL-TIME RT-PCR OF 92 GENES (87 CONTENT AND 5 HOUSEKEEPING) TO CLASSIFY TUMOR INTO MAIN CANCER TYPE AND SUBTYPE, UTILIZING FORMALIN-FIXED PARAFFIN-EMBEDDED TISSUE, ALGORITHM REPORTED AS A PROBABILITY OF A PREDICTED MAIN CANCER TYPE AND SUBTYPE	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81541	ONCOLOGY (PROSTATE), MRNA GENE EXPRESSION PROFILING BY REAL-TIME RT-PCR OF 46 GENES (31 CONTENT AND 15 HOUSEKEEPING), UTLIZING FORMALIN-FIXED PARAFFIN-EMBEDDED TISSUE, ALGORITHM REPORTED AS A DISEASE-SPECIFIC MORTALITY RISK SCORE	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81542	ONCOLOGY (PROSTATE), MRNA, MICROARRAY GENE EXPRESSION PROFILING OF 22 CONTENT GENES, UTILIZING FORMALIN-FIXED PARAFFIN-EMBEDDED TISSUE, ALGORITHM REPORTED AS METASIS RISK SCORE	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81546	ONCOLOGY (THYROID), MRNA, GENE EXPRESSION ANALYSIS OF 10,196 GENES, UTILIZING FINE NEEDLE ASPIRATE, ALGORITHM REPORTED AS A CATEGORICAL RESULT (EG, BENIGN OR SUSPICIOUS)	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81551	ONCOLOGY (PROSTATE), PROMOTER METHYLATION PROFILING BY REAL-TIME PCR OF 3 GENES (GSTP1, APC, RASSF1), UTILIZING FORMALIN-FIXED PARAFFIN-EMBEDDED TISSUE, ALGORITHM REPORTED AS A LIKELIHOOD OF PROSTATE CANCER DETECTION ON REPEAT BIOPSY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81552	ONCOLOGY (UVEAL MELANOMA) MRNA, GENE EXPRESSION PROFILING BY REAL-TIME RT PCR OF 15 GENES (12 CONTENT AND 3 HOUSEKEEPING), UTILIZING FINE NEEDLE ASPIRATE OR FORMALIN-FIXED PARAFFIN-EMBEDDED TSIISUE, ALGORITHM REPORTED AS RISK OF METASTASIS	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81554	PULMONARY DISEASE (IDIOPATHIC PULMONARY FIBROSIS [IPF]), mRNA, GENE EXPRESSION ANALYSIS OF 190 GENES, UTILIZING TRANSBRONCHIAL BIOPSIES, DIAGNOSTIC ALGORITHM REPORTED AS CATEGORICAL RESULT (EG, POSITIVE OR NEGATIVE FOR HIGH PROBABILITY OF USUAL INTERSTITIAL PNEUMONIA [UIP])	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81560	TRANSPLANTATION MEDICINE (ALLOGRAFT REJECTION, PEDIATRIC LIVER AND SMALL BOWEL), MEASUREMENT OF DONOR AND THIRD-PARTY-INDUCED CD154+T CYTOTOXIC MEMORY CELLS, UTILIZING WHOLE PERIPHERAL BLOOD, ALGORITHM REPORTED AS A REJECTION RISK SCORE	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP	

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81595	CARDIOLOGY (HEART TRANSPLANT), MRNA, GENE EXPRESSION PROFILING BY REAL-TIME QUANTITATIVE PCR OF 20 GENES (11 CONTENT AND 9 HOUSEKEEPING), UTILIZING SUBFRACTION OF PERIPHERAL BLOOD, ALGORITHM REPORTED AS A REJECTION RISK SCORE	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
81599	UNLISTED MULTIANALYTE ASSAY WITH ALGORITHMIC ANALYSIS	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303, CMP201923	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
84999	UNLISTED CHEMISTRY PROCEDURE **SEE CORPORATE MEDICAL POLICIES FOR GUIDELINES ABOUT SPECIFIC TESTS **	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP202405	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
85999	UNLISTED HEMATOLOGY PROCEDURE AUTOLOGOUS PLATELET SEALANT GRAFT IS INVESTIGATIONAL	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP202405	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
86849	UNLISTED IMMUNOLOGY PROCEDURE **SEE CORPORATE MEDICAL POLICIES FOR GUIDELINES ABOUT SPECIFIC TESTS **	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP202405	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
88235	TISSUE CULTURE FOR NON\NEOPLASTIC DISORDERS; AMNIOTIC FLUID OR CHORIONIC VILLUS CELLS	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
88241	THAWING AND EXPANSION OF FROZEN CELLS, EACH ALIQUOT	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
88245	CHROMOSOME ANALYSIS FOR BREAKAGE SYNDROMES; BASELINE SISTER CHROMATID EXCHANGE (SCE), 20\25 CELLS	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
88248	CHROMOSOME ANALYSIS FOR BREAKAGE SYNDROMES; BASELINE BREAKAGE, SCORE 50\100 CELLS, COUNT 20 CELLS, 2 KARYOTYPES (EG, FOR ATAXIA TELANGIECTASIA, FANCONI ANEMIA, FRAGILE X)	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
88249	CHROMOSOME ANALYSIS FOR BREAKAGE SYNDROMES; SCORE 100 CELLS, C;ASTPGEM STRESS (EG, DIEPOXYBUTANE, MITOMYCIN C, IONIZING RADIATION, UV RADIATION)	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
88261	CHROMOSOME ANALYSIS; COUNT 5 CELLS, 1 KARYOTYPE, WITH BANDING	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
88262	CHROMOSOME ANALYSIS; COUNT 15 TO 20 CELLS, 2 KARYOTYPES, WITH BANDING	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
88263	CHROMOSOME ANALYSIS; COUNT 45 CELLS FOR MOSAICISM, 2 KARYOTYPES, WITH BANDING	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
88269	CHROMOSOME ANALYSIS, IN SITU FOR AMNIOTIC FLUID CELLS, COUNT CELLS FROM 6 \ 12 COLONIES, 1 KARYOTYPE, WITH BANDING	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
88271	MOLECULAR CYTOGENETICS; DNA PROBE, EACH (EG, FISH)	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
88272	MOLECULAR CYTOGENETICS; CHROMOSOMAL IN SITU HYBRIDIZATION, ANALYZE 3 5 CELLS (EG, FOR DERIVATIVES AND MARKERS)	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
88273	MOLECULAR CYTOGENETICS; CHROMOSOMAL IN SITU HYBRIDIZATION, ANALYZE 10 30 CELLS (EG, FOR MICRODELETIONS)	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
88274	MOLECULAR CYTOGENETICS; INTERPHASE IN SITU HYBRIDIZATION, ANALYZE 25 99 CELLS	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
88275	MOLECULAR CYTOGENETICS; INTERPHASE IN SITU HYBRIDIZATION, ANALYZE 100 300 CELLS	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
88283	CHROMOSOME ANALYSIS; ADDITIONAL SPECIALIZED BANDING TECHNIQUE (EG. NOR, C\BANDING)	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
88289	CHROMOSOME ANALYSIS; ADDITIONAL HIGH RESOLUTION STUDY	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
88299	UNLISTED CYTOGENETIC STUDY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP202405	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
89290	BIOPSY, OOCYTE POLAR OR EMBRYO BLASTOMERE, MICROTECHNIQUE (FOR PRE\IMPLANTATION GENETIC DIAGNOSIS); LESS THAN OR EQUAL TO 5 EMBRYOS	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
89291	BIOPSY, OOCYTE POLAR BODY OR EMBRYO BLASTOMERE, MICROTECHNIQUE (FOR PRE\IMPLANTATION GENETIC DIAGNOSIS); GREATER THAN 5 EMBRYOS	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
90832	PSYCHOTHERAPY, 30 MINUTES WITH PATIENT	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY (See Notes)	CMP202506	PRIOR AUTHORIZATION NOT REQUIRED		Commercial Only: Prior Authorization required if service is for eye movement desensitization and reprocessing (EMDR) therapy
90833	PSYCHOTHERAPY, 30 MINUTES WITH PATIENT WHEN PERFORMED WITH AN EVALUATION AND MANAGEMENT SERVICE (LIST SEPARATELY IN ADDITION TO THE CODE FOR PRIMARY PROCEDURE)	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY (See Notes)	CMP202506	PRIOR AUTHORIZATION NOT REQUIRED		Commercial Only: Prior Authorization required if service is for eye movement desensitization and reprocessing (EMDR) therapy
90834	PSYCHOTHERAPY, 45 MINUTES WITH PATIENT	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY (See Notes)	CMP202506	PRIOR AUTHORIZATION NOT REQUIRED		Commercial Only: Prior Authorization required if service is for eye movement desensitization and reprocessing (EMDR) therapy

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90836	PSYCHOTHERAPY, 45 MINUTES WITH PATIENT WHEN PERFORMED WITH AN EVALUATION AND MANAGEMENT SERVICE (LIST SEPARATELY IN ADDITION TO THE CODE FOR PRIMARY PROCEDURE)	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY (See Notes)	CMP202506	PRIOR AUTHORIZATION NOT REQUIRED		Commercial Only: Prior Authorization required if service is for eye movement desensitization and reprocessing (EMDR) therapy
90837	PSYCHOTHERAPY, 60 MINUTES WITH PATIENT	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY (See Notes)	CMP202506	PRIOR AUTHORIZATION NOT REQUIRED		Commercial Only: Prior Authorization required if service is for eye movement desensitization and reprocessing (EMDR) therapy
90838	PSYCHOTHERAPY, 60 MINUTES WITH PATIENT WHEN PERFORMED WITH AN EVALUATION AND MANAGEMENT SERVICE (LIST SEPARATELY IN ADDITION TO THE CODE FOR PRIMARY PROCEDURE)	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY (See Notes)	CMP202506	PRIOR AUTHORIZATION NOT REQUIRED		Commercial Only: Prior Authorization required if service is for eye movement desensitization and reprocessing (EMDR) therapy
90839	PSYCHOTHERAPY FOR CRISIS; FIRST 60 MINUTES	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY (See Notes)	CMP202506	PRIOR AUTHORIZATION NOT REQUIRED		Commercial Only: Prior Authorization required if service is for eye movement desensitization and reprocessing (EMDR) therapy
90840	PSYCHOTHERAPY FOR CRISIS; EACH ADDITIONAL 30 MINUTES (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY SERVICE)	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY (See Notes)	CMP202506	PRIOR AUTHORIZATION NOT REQUIRED		Commercial Only: Prior Authorization required if service is for eye movement desensitization and reprocessing (EMDR) therapy
90845	PSYCHOANALYSIS	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY (See Notes)	CMP202506	PRIOR AUTHORIZATION NOT REQUIRED		Commercial Only: Prior Authorization required if service is for eye movement desensitization and reprocessing (EMDR) therapy
90846	FAMILY PSYCHOTHERAPY (WITHOUT THE PATIENT PRESENT), 50 MINUTES	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY (See Notes)	CMP202506	PRIOR AUTHORIZATION NOT REQUIRED		Commercial Only: Prior Authorization required if service is for eye movement desensitization and reprocessing (EMDR) therapy
90847	FAMILY PSYCHOTHERAPY (CONJOINT PSYCHOTHERAPY) (WITH PATIENT PRESENT), 50 MINUTES	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY (See Notes)	CMP202506	PRIOR AUTHORIZATION NOT REQUIRED		Commercial Only: Prior Authorization required if service is for eye movement desensitization and reprocessing (EMDR) therapy
90849	MULTIPLE-FAMILY GROUP PSYCHOTHERAPY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY (See Notes)	CMP202506	PRIOR AUTHORIZATION NOT REQUIRED		Commercial Only: Prior Authorization required if service is for eye movement desensitization and reprocessing (EMDR) therapy
90853	GROUP PSYCHOTHERAPY (OTHER THAN OF A MULTIPLE-FAMILY GROUP)	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY (See Notes)	CMP202506	PRIOR AUTHORIZATION NOT REQUIRED		Commercial Only: Prior Authorization required if service is for eye movement desensitization and reprocessing (EMDR) therapy
90863	PHARMACOLOGIC MANAGEMENT, INCLUDING PRESCRIPTION AND REVIEW OF MEDICATION, WHEN PERFORMED WITH PSYCHOTHERAPY SERVICES (LIST SEPARATELY IN ADDITION TO THE CODE FOR PRIMARY PROCEDURE)	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY (See Notes)	CMP202506	PRIOR AUTHORIZATION NOT REQUIRED		Commercial Only: Prior Authorization required if service is for eye movement desensitization and reprocessing (EMDR) therapy
90865	NARCOSYNTHESIS FOR PSYCHIATRIC DIAGNOSTIC AND THERAPEUTIC PURPOSES (EG, SODIUM AMOBARBITAL (AMYTAL) INTERVIEW)	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY (See Notes)	CMP202506	PRIOR AUTHORIZATION NOT REQUIRED		Commercial Only: Prior Authorization required if service is for eye movement desensitization and reprocessing (EMDR) therapy
90867	THERAPEUTIC REPETITIVE TRANSCRANIAL MAGNETIC STIMULATION (TMS) TREATMENT; INITIAL, INCLUDING CORTICAL MAPPING, MOTOR THRESHOLD DETERMINATION, DELIVERY AND MANAGEMENT	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP202506	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
90868	THERAPEUTIC REPETITIVE TRANSCRANIAL MAGNETIC STIMULATION (TMS) TREATMENT; SUBSEQUENT DELIVERY AND MANAGEMENT, PER SESSION	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP202506	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
90869	THERAPEUTIC REPETETIVE TRANSCRANIAL MAGNETIC STIMULATION (TMS) TREATMENT; SUBSEQUENT MOTOR THRESHOLD RE\DETERMINATION WITH DELIVERY AND MANAGEMENT	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP202506	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
90870	ELECTROCONVULSIVE THERAPY (INCLUDES NECESSARY MONITORING)	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY (See Notes)	CMP202506	PRIOR AUTHORIZATION NOT REQUIRED		Commercial Only: Prior Authorization required if service is for eye movement desensitization and reprocessing (EMDR) therapy
90875	INDIVIDUAL PSYCHOPHYSIOLOGICAL THERAPY INCORPORATING BIOFEEDBACK TRAINING BY ANY MODALITY (FACE-TO-FACE WITH THE PATIENT), WITH PSYCHOTHERAPY (EG, INSIGHT ORIENTED, BEHAVIOR MODIFYING OR SUPPORTIVE PSYCHOTHERAPY); 30 MINUTES	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY (See Notes)	CMP202506	PRIOR AUTHORIZATION NOT REQUIRED		Commercial Only: Prior Authorization required if service is for eye movement desensitization and reprocessing (EMDR) therapy
90876	INDIVIDUAL PSYCHOPHYSIOLOGICAL THERAPY INCORPORATING BIOFEEDBACK TRAINING BY ANY MODALITY (FACE-TO-FACE WITH THE PATIENT), WITH PSYCHOTHERAPY (EG, INSIGHT ORIENTED, BEHAVIOR MODIFYING OR SUPPORTIVE PSYCHOTHERAPY); 45 MINUTES	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY (See Notes)	CMP202506	PRIOR AUTHORIZATION NOT REQUIRED		Commercial Only: Prior Authorization required if service is for eye movement desensitization and reprocessing (EMDR) therapy
90880	HYPNOTHERAPY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY (See Notes)	CMP202506	PRIOR AUTHORIZATION NOT REQUIRED		Commercial Only: Prior Authorization required if service is for eye movement desensitization and reprocessing (EMDR) therapy
90882	ENVIRONMENTAL INTERVENTION FOR MEDICAL MANAGEMENT PURPOSES ON A PSYCHIATRIC PATIENTS BEHALF WITH AGENCIES, EMPLOYERS, OR INSTITUTIONS	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY (See Notes)	CMP202506	PRIOR AUTHORIZATION NOT REQUIRED		Commercial Only: Prior Authorization required if service is for eye movement desensitization and reprocessing (EMDR) therapy
90885	PSYCHIATRIC EVALUATION OF HOSPITAL RECORDS, OTHER PSYCHIATRIC REPORTS, PSYCHOMETRIC AND/OR PROJECTIVE TESTS, AND OTHER ACCUMULATED DATA FOR MEDICAL DIAGNOSTIC PURPOSES	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY (See Notes)	CMP202506	PRIOR AUTHORIZATION NOT REQUIRED		Commercial Only: Prior Authorization required if service is for eye movement desensitization and reprocessing (EMDR) therapy
90887	INTERPRETATION OR EXPLANATION OF RESULTS OF PSYCHIATRIC, OTHER MEDICAL EXAMINATIONS AND PROCEDURES, OR OTHER ACCUMULATED DATA TO FAMILY OR OTHER RESPONSIBLE PERSONS, OR ADVISING THEM HOW TO ASSIST PATIENT	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY (See Notes)	CMP202506	PRIOR AUTHORIZATION NOT REQUIRED		Commercial Only: Prior Authorization required if service is for eye movement desensitization and reprocessing (EMDR) therapy
90889	PREPARATION OF REPORT OF PATIENTS PSYCHIATRIC STATUS, HISTORY, TREATMENT, OR PROGRESS (OTHER THAN FOR LEGAL OR CONSULTATIVE PURPOSES) FOR OTHER INDIVIDUALS, AGENCIES, OR INSURANCE CARRIERS	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY (See Notes)	CMP202506	PRIOR AUTHORIZATION NOT REQUIRED		Commercial Only: Prior Authorization required if service is for eye movement desensitization and reprocessing (EMDR) therapy
90899	UNLISTED PSYCHIATRIC SERVICE OR PROCEDURE	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY (See Notes)	CMP202506	PRIOR AUTHORIZATION NOT REQUIRED		Commercial Only: Prior Authorization required if service is for eye movement desensitization and reprocessing (EMDR) therapy

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91299	UNLISTED DIAGNOSTIC GASTROENTEROLOGY PROCEDURE	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP202405	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
92065	ORTHOPTIC TRAINING; PERFORMED BY A PHYSICIAN OR OTHER QUALIFIED HEALTH CARE PROFESSIONAL	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201103	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201103	
92066	ORTHOPTIC TRAINING; UNDER SUPERVISION OF A PHYSICIAN OR OTHER QUALIFIED HEALTH CARE PROFESSIONAL	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201103	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201103	
92499	UNLISTED OPHTHALMOLOGICAL SERVICE OR PROCEDURE	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP2006-G, CMP202405	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
92700	UNLISTED OTORHINOLARYNGOLOGICAL SERVICE OR PROCEDURE	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP94007	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
95199	UNLISTED ALLERGY/CLINICAL IMMUNOLOGIC SERVICE OR PROCEDURE	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP200224, CMP202405	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
95803	ACTIGRAPHY TESTING, RECORDING, ANALYSIS, INTERPRETATION, AND REPORT (MINIMUM OF 72 HOURS TO 14 CONSECUTIVE DAYS OF RECORDING)	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP2018-C	PRIOR AUTHORIZATION REQUIRED-FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
95999	UNLISTED NEUROLOGICAL OR NEUROMUSCULAR DIAGNOSTIC PROCEDURE ** SYMPATHETIC PERIPHERAL AUTONOMIC SKIN (OR SURFACE) POTENTIALS ARE INVESTIGATIONAL.**	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES (See Notes)	MCG A-1050 (CMP202406)	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
96000	COMPREHENSIVE COMPUTER-BASED MOTION ANALYSIS BY VIDEO-TAPING AND 3D KINEMATICS	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES (See Notes)	MCG A-0720 (CMP202407)	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP	
96127	BRIEF EMOTIONAL/BEHAVIORAL ASSESSMENT (EG, DEPRESSION INVENTORY, ATTENTION-DEFICIT/HYPERACTIVITY DISORDER (ADHD) SCALE), WITH SCORING AND DOCUMENTATION, PER STANDARDIZED INSTRUMENT	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES (See Notes)	MCG B-806-T (CMP202014)	PRIOR AUTHORIZATION REQUIRED-FOLLOW MEDICARE COVERAGE CRITERIA (See Notes)	CMS	Only require Prior Auth when services are for ABA therapy
96379	UNLISTED THERAPEUTIC, PROPHYLACTIC, OR DIAGNOSTIC INTRAVENOUS OR INTRA ARTERIAL INJECTION OR INFUSION	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP202405	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
96549	UNLISTED CHEMOTHERAPY PROCEDURE	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201005, CMP202405	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
96904	WHOLE BODY INTEGUMENTARY PHOTOGRAPHY, FOR MONITORING OF HIGH RISK PATIENTS WITH DYSPLASTIC NEVUS SYNDROME OR A HISTORY OF DYSPLASTIC NEVI, OR PATIENTS WITH A PERSONAL OR FAMILIAL HISTORY OF MELANOMA	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP200903	PRIOR AUTHORIZATION NOT REQUIRED		
96920	LASER TREATMENT FOR INFLAMMATORY SKIN DISEASE (PSORIASIS); TOTAL AREA LESS THAN 250 SQ CM	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP94057	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
96921	LASER TREATMENT FOR INFLAMMATORY SKIN DISEASE (PSORIASIS); 250 SQ CM TO 500 SQ CM	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP94057	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
96922	LASER TREATMENT FOR INFLAMMATORY SKIN DISEASE (PSORIASIS); OVER 500 SQ CM	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP94057	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
96999	UNLISTED SPECIAL DERMATOLOGICAL SERVICE OR PROCEDURE	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP94057, CMP20090, CMP202405	PRIOR AUTHORIZATION REQUIRED-FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
97151	BEHAVIOR IDENTIFICATION ASSESSMENT, ADMINISTERED BY A PHYSICIAN OR OTHER QUALIFIED HEALTH CARE PROFESSIONAL, EACH 15 MINUTES OF THE PHYSICIAN'S OR OTHER QUALIFIED HEALTH CARE PROFESSIONAL'S TIME FACE-TO-FACE WITH PATIENT AND/OR GUARDIAN(S)/CAREGIVER(S) ADMINISTERING ASSESSMENTS AND DISCUSSING FINDINGS AND RECOMMENDATIONS, AND NON-FACE-TO-FACE ANALYZING PAST DATA, SCORING/INTERPRETING THE ASSESSMENT, AND PREPARING THE REPORT/TREATMENT PLAN	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES (See Notes)	MCG B-806-T (CMP202014)	PRIOR AUTHORIZATION NOT REQUIRED		Only requires Prior Auth when services are for ABA therapy (Commercial LOB).
97152	BEHAVIOR IDENTIFICATION-SUPPORTING ASSESSMENT, ADMINISTERED BY ONE TECHNICIAN UNDER THE DIRECTION OF A PHYSICIAN OR OTHER QUALIFIED HEALTH CARE PROFESSIONAL, FACE-TO-FACE WITH THE PATIENT, EACH 15 MINUTES	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES (See Notes)	MCG B-806-T (CMP202014)	PRIOR AUTHORIZATION NOT REQUIRED		
97153	ADAPTIVE BEHAVIOR TREATMENT BY PROTOCOL, ADMINISTERED BY TECHNICIAN UNDER THE DIRECTION OF A PHYSICIAN OR OTHER QUALIFIED HEALTH CARE PROFESSIONAL, FACE-TO-FACE WITH ONE PATIENT, EACH 15 MINUTES	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES (See Notes)	MCG B-806-T (CMP202014)	PRIOR AUTHORIZATION NOT REQUIRED		
97154	GROUP ADAPTIVE BEHAVIOR TREATMENT BY PROTOCOL, ADMINISTERED BY TECHNICIAN UNDER THE DIRECTION OF A PHYSICIAN OR OTHER QUALIFIED HEALTH CARE PROFESSIONAL, FACE-TO-FACE WITH TWO OR MORE PATIENTS, EACH 15 MINUTES	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES (See Notes)	MCG B-806-T (CMP202014)	PRIOR AUTHORIZATION NOT REQUIRED		
97155	ADAPTIVE BEHAVIOR TREATMENT WITH PROTOCOL MODIFICATION, ADMINISTERED BY PHYSICIAN OR OTHER QUALIFIED HEALTH CARE PROFESSIONAL, WHICH MAY INCLUDE SIMULTANEOUS DIRECTION OF TECHNICIAN, FACE-TO-FACE WITH ONE PATIENT, EACH 15 MINUTES	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES (See Notes)	MCG B-806-T (CMP202014)	PRIOR AUTHORIZATION NOT REQUIRED		

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97156	FAMILY ADAPTIVE BEHAVIOR TREATMENT GUIDANCE, ADMINISTERED BY PHYSICIAN OR OTHER QUALIFIED HEALTH CARE PROFESSIONAL (WITH OR WITHOUT THE PATIENT PRESENT), FACE-TO-FACE WITH GUARDIAN(S)/CAREGIVER(S), EACH 15 MINUTES	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES (See Notes)	MCG B-806-T (CMP202014)	PRIOR AUTHORIZATION NOT REQUIRED		
97157	MULTIPLE-FAMILY GROUP ADAPTIVE BEHAVIOR TREATMENT GUIDANCE, ADMINISTERED BY PHYSICIAN OR OTHER QUALIFIED HEALTH CARE PROFESSIONAL (WITHOUT THE PATIENT PRESENT), FACE-TO-FACE WITH MULTIPLE SETS OF GUARDIANS/CAREGIVERS, EACH 15 MINUTES	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES (See Notes)	MCG B-806-T (CMP202014)	PRIOR AUTHORIZATION NOT REQUIRED		
97158	GROUP ADAPTIVE BEHAVIOR TREATMENT WITH PROTOCOL MODIFICATION, ADMINISTERED BY PHYSICIAN OR OTHER QUALIFIED HEALTH CARE PROFESSIONAL, FACE-TO-FACE WITH MULTIPLE PATIENTS, EACH 15 MINUTES	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES (See Notes)	MCG B-806-T (CMP202014)	PRIOR AUTHORIZATION NOT 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 REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED-FOLLOW MEDICARE COVERAGE CRITERIA (See Notes)	CMS	
0009M	FETAL ANEUPLOIDY (TRISOMY 21, and 18) DNA SEQUENCE ANALYSIS OF SELECTED REGIONS USING MATERNAL PLASMA, ALGORITHM REPORTED AS A RISK SCORE FOR EACH TRISOMY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0009U	ONCOLOGY (BREAST CANCER), ERBB2 (HER2) COPY NUMBER BY FISH, TUMOR CELLS FROM FORMALIN-FIXED PARAFFIN-EMBEDDED TISSUE ISOLATED USING IMAGE-BASED DIELECTROPHORESIS (DEP) SORTING, REPORTED AS ERBB2 GENE AMPLIFIED OR NON-AMPLIFIED	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG A-0766 Breast Cancer - HER2 Testing	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0011M	ONCOLOGY PROSTATE 8 CA MRNA 12 GEN ALG	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0012M	ONCOLOGY (UROTHELIAL), mRNA, GENE EXPRESSION PROFILING BY REAL-TIME QUANTITATIVE PCR OF FIVE GENES (MDK, HOXA13, CDC2 [CDK 1], IGFBP5, AND XCR2), UTILIZING URINE, ALGORITHM REPORTED AS A RISH SCORE FOR HAVING UROTHELIAL CARCINOMA	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0013M	ONCOLOGY (UROTHELIAL), mRNA, GENE EXPRESSION PROFILING BY REAL-TIME QUANTITATIVE PCR OF FIVE GENES (MDK, HOXA 13, CDC2 [CDK 1], IGFBP5, AND CXCR2), UTILIZING URINE, ALGORITHM REPORTED AS A RISK SCORE FOR HAVING RECURRENT UROTHELIAL CARCINOMA	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0015M	ADRENAL CORTICAL TUMOR, BIOCHEMICAL ASSAY OF 25 STEROID MARKERS, UTILIZING 24-HOUR URINE SPECIMEN AND CLINICAL PARAMETERS, PROGNOSTIC ALGORITHM REPORTED AS A CLINICAL RISK AND INTEGRATED CLINICAL STEROID RISK FOR ADRENAL CORTICAL CARCINOMA, ADENOMA, OR OTHER ADRENAL MALIGNANCY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0016M	ONCOLOGY (BLADDER), MRNA, MICROARRAY GENE EXPRESSION PROFILING OF 209 GENES, UTILIZING FORMALIN-FIXED PARAFFIN-EMBEDDED TISSUE, ALGORITHM REPORTED AS MOLECULAR SUBTYPE (LUMINAL, LUMINAL INFILTRATED, BASAL, BASAL CLAUDIN-LOW, NEUROENDOCRINE-LIKE)	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0016U	ONCOLOGY (HEMATOLYMPHOID NEOPLASIA), RNA, BCR/ABL1 MAJOR AND MINOR BREAKPOINT FUSION TRANSCRIPTS, QUANTITATIVE PCR AMPLIFICATION, BLOOD OR BONE MARROW, REPORT OF FUSION NOT DETECTED OR DETECTED WITH QUANTITATION	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0017M	ONCOLOGY (DIFFUSE LARGE B-CELL LYMPHOMA [DLBCL]), mRNA, GENE EXPRESSION PROFILING BY FLUORESCENT PROBE HYBRIDIZATION OF 20 GENES, FORMALIN-FIXED PARAFFIN-EMBEDDED TISSUE, ALGORITHM REPORTED AS CELL OF ORIGIN	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0017U	ONCOLOGY (HEMATOLYMPHOID NEOPLASIA), JAK2 MUTATION, DNA, PCR AMPLIFICATION OF EXONS 12-14 AND SEQUENCE ANALYSIS, BLOOD OR BONE MARROW, REPORT OF JAK2 MUTATION NOT DETECTED OR DETECTED	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0018M	TRANSPLANTATION MEDICINE (ALLOGRAFT REJECTION, RENAL), MEASUREMENT OF DONOR AND THIRD-PARTY-INDUCED CD154+T-CYTOTOXIC MEMORY CELLS, UTILIZING WHOLE PERIPHERAL BLOOD, ALGORITHM REPORTED AS A REJECTION RISK SCORE	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP	
0018U	ONCOLOGY (THYROID), MICRORNA PROFILING BY RT-PCR OF 10 MICRORNA SEQUENCES, UTILIZING FINE NEEDLE ASPIRATE, ALGORITHM REPORTED AS A POSITIVE OR NEGATIVE RESULT FOR MODERATE TO HIGH RISK OF MALIGNANCY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0019U	ONCOLOGY, RNA, GENE EXPRESSION BY WHOLE TRANSCRIPTOME SEQUENCING, FORMALIN-FIXED PARAFFIN EMBEDDED TISSUE OR FRESH FROZEN TISSUE, PREDICTIVE ALGORITHM REPORTED AS POTENTIAL TARGETS FOR THERAPEUTIC AGENTS	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	

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0021U	ONCOLOGY (PROSTATE), DETECTION OF 8 AUTOANTIBODIES (ARF 6, NKX3-1, 5'-UTR-BMI 1, CEP 164, 3'-UTR-ROPPORIN, DESMOCOLLIN, AURKAIP-1, CSNK2A2), MULTIPLEXED IMMUNOASSAY AND FLOW CYTOMETRY SERUM, ALGORITHM REPORTED AS RISK SCORE	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0023U	ONCOLOGY (ACUTE MYELOGENOUS LEUKEMIA), DNA, GENOTYPING OF INTERNAL TANDEM DUPLICATION, P.D835, P.I836, USING MONONUCLEAR CELLS, REPORTED AS DETECTION OR NON-DETECTION OF FLT3 MUTATION AND INDICATION FOR OR AGAINST THE USE OF MIDOSTAURIN	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0026U	ONCOLOGY (THYROID), DNA AND mRNA OF 112 GENES, NEXT-GENERATION SEQUENCING, FINE NEEDLE ASPIRATE OF THYROID NODULE, ALGORITHMIC ANALYSIS REPORTED AS A CATEGORICAL RESULT (REFER TO 2018 CPT BOOK FOR COMPLETE DESCRIPTION)	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0027U	JAK2 (JANUS KINASE 2) (EG, MYELOPROLIFERATIVE DISORDER) GENE ANALYSIS, TARGETED SEQUENCE ANALYSIS EXONS 12-15	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0031U	CYP1A2 CYTOCHROME P450 FAMILY 1, SUBFAMILY A, MEMBER 2) (EG, DRUG METABOLISM) GENE ANALYSIS, COMMON VARIANTS (IE, *1F, *1K, *6, *7)	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0032U	COMT (CATECHOL-O-METHYLTRANSFERASE) (DRUG METABOLISM) GENE ANALYSIS, c.472G>A (rs4680) VARIANT	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0034U	TPMT (THIOPURINE S-METHYLTRANSFERASE), NUDT15 (NUDIX HYDROXYLASE 15) (EG, THIOPURINE METABOLISM) GENE ANALYSIS, COMMON VARIANTS (REFER TO 2018 CPT BOOK FOR COMPLETE DESCRIPTION)	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0036U	EXOME (IE, SOMATIC MUTATIONS); PAIRED FORMALIN FIXED PARAFFIN EMBEDDED TUMOR TISSUE AND NORMAL SPECIMEN, SEQUENCE ANALYSES	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0037U	TARGETED GENOMIC SEQUENCE ANALYSIS, SOLID ORGAN NEOPLASM, DNA ANALYSIS OF 324 GENES, INTERROGATION FOR SEQUENCE VARIANTS, GENE COPY NUMBER AMPLIFICATIONS, GENE REARRANGEMENTS (REFER TO 2018 CPT BOOK FOR COMPLETE DESCRIPTION)	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0040U	BCR/ABL1 (T(9;22)) (EG, CHRONIC MYELOGENOUS LEUKEMIA) TRANSLOCATION ANALYSIS, MAJOR BREAKPOINT, QUANTITATIVE	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0045U	ONCOLOGY (BREAST), ONCOTYPE DX BREAST DCIS SCORE TEST	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0047U	ONCOTYPE DX GENOMIC PROSTATE SCORE	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0048U	MSK-IMPACT (INTEGRATED MUTATION PROFILING OF ACTIONABLE CANCER TARGETS)	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0049U	NPM1 GENE ANALYSIS QUAN	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0050U	TRGT GEN SEQ DNA 194 GENES	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0055U	CARD HRT TRNSPL 96 DNA SEQ	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0058U	ONC MERKEL CLL CARC SRM QUAN	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0059U	ONC MERKEL CLL CARC SRM +/-	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0067U	ONCOLOGY (BREAST), IMMUNOHISTOCHEMISTRY, PROTEIN EXPRESSION PROFILING OF 4 BIOMARKERS (MATRIX METALLOPROTEINASE-1 (MMP-1), CARCINOEMBRYONIC ANTIGEN-RELATED CELL ADHESION MOLECULE 6 (CEACAM6), HYALURONOGLUCOSAMINIDASE (HYAL1), HIGHLY EXPRESSED IN CANCER PROTEIN (HEC1)), FORMALIN-FIXED PARAFFIN-EMBEDDED PRECANCEROUS BREAST TISSUE, ALGORITHM REPORTED AS CARCINOMA RISK SCORE	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	CMP201303	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0070U	CYP2D6 (CYTOCHROME P450, FAMILY 2, SUBFAMILY D, POLYPEPTIDE 6) (EG, DRUG METABOLISM) GENE ANALYSIS, COMMON AND SELECT RARE VARIANTS (IE, *2, *3, *4, *4N, *5, *6, *7, *8, *9, *10, *11, *12, *13, *14A, *14B, *15, *17, *29, *35, *36, *41, *57, *61, *63, *68, *83, *XN)	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0071U	CYP2D6 (CYTOCHROME P450, FAMILY 2, SUBFAMILY D, POLYPEPTIDE 6) (EG, DRUG METABOLISM) GENE ANALYSIS, FULL GENE SEQUENCE (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	

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0072U	CYP2D6 (CYTOCHROME P450, FAMILY 2, SUBFAMILY D, POLYPEPTIDE 6) (EG, DRUG METABOLISM) GENE ANALYSIS, TARGETED SEQUENCE ANALYSIS (IE, CYP2D6-2D7 HYBRID GENE) (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0073U	CYP2D6 (CYTOCHROME P450, FAMILY 2, SUBFAMILY D, POLYPEPTIDE 6) (EG, DRUG METABOLISM) GENE ANALYSIS, TARGETED SEQUENCE ANALYSIS (IE, CYP2D7-2D6 HYBRID GENE) (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0074U	CYP2D6 (CYTOCHROME P450, FAMILY 2, SUBFAMILY D, POLYPEPTIDE 6) (EG, DRUG METABOLISM) GENE ANALYSIS, TARGETED SEQUENCE ANALYSIS (IE, NON-DUPLICATED GENE WHEN DUPLICATION/MULTIPLICATION IS TRANS) (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0075T	TRANSCATHETER PLACEMENT OF EXTRACRANIAL VERTEBRAL ARTERY STENT(S), INCLUDING RADIOLOGIC SUPERVISION AND INTERPRETATION, OPEN OR PERCUTANEOUS; INITIAL VESSEL	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP202104	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP	
0075U	CYP2D6 (CYTOCHROME P450, FAMILY 2, SUBFAMILY D, POLYPEPTIDE 6) (EG, DRUG METABOLISM) GENE ANALYSIS, TARGETED SEQUENCE ANALYSIS (IE, 5' GENE DUPLICATION/MULTIPLICATION) (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0076T	TRANSCATHETER PLACEMENT OF EXTRACRANIAL VERTEBRAL ARTERY STENT(S), INCLUDING RADIOLOGIC SUPERVISION AND INTERPRETATION, OPEN OR PERCUTANEOUS; VESSEL EACH ADDITIONAL VESSEL) (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP202104	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP	
0076U	CYP2D6 (CYTOCHROME P450, FAMILY 2, SUBFAMILY D, POLYPEPTIDE 6) (EG, DRUG METABOLISM) GENE ANALYSIS, TARGETED SEQUENCE ANALYSIS (IE, 3' GENE DUPLICATION/MULTIPLICATION) (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0080U	ONCOLOGY (LUNG), MASS SPECTROMETRIC ANALYSIS OF GALECTIN-3-BINDING PROTEIN AND SCAVENGER RECEPTOR CYSTEINE-RICH TYPE 1 PROTEIN M130, WITH FIVE CLINICAL RISK FACTORS (AGE, SMOKING STATUS, NODULE DIAMETER, NODULE-SPICULATION STATUS AND NODULE LOCATION), UTILIZING PLASMA, ALGORITHM REPORTED AS A CATEGORICAL PROBABILITY OF MALINGNANCY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0087U	CARDIOLOGY (HEART TRANSPLANT), MRNA GENE EXPRESSION PROFILING BY MICROARRAY OF 1283 GENES, TRANSPLANT BIOPSY TISSUE, ALLOGRAFT REJECTION AND INJURY ALGORITHM REPORTED AS A PROBABILITY SCORE	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0088U	TRANSPLANTATION MEDICINE (KIDNEY ALLOGRAFT REJECTION), MICROARRAY GENE EXPRESSION PROFILING OF 1494 GENES, UTILIZING TRANSPLANT BIOPSY TISSUE, ALGORITHM REPORTED AS A PROBABILITY SCORE FOR REJECTION	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0089U	ONCOLOGY (MELANOMA), GENE EXPRESSION PROFILING BY RTQPCR, PRAME AND LINC00518, SUPERFICIAL COLLECTION USING ADHESIVE PATCH(ES)	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
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 REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0094U	GENOME (EG, UNEXPLAINED CONSTITUTIONAL OR HERITABLE DISORDER OR SYNDROME), RAPID SEQUENCE ANALYSIS	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION NOT 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 REQUIRED - MEDICAL POLICY	CMP200813	PRIOR AUTHORIZATION NOT 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 REQUIRED - MEDICAL POLICY	CMP200813	PRIOR AUTHORIZATION NOT 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 REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION NOT REQUIRED		

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0103U	HEREDITARY OVARIAN CANCER (EG, HEREDITARY OVARIAN CANCER, HEREDITARY ENDOMETRIAL CANCER), GENOMIC SEQUENCE ANALYSIS PANEL UTILIZING A COMBINATION OF NGS, SANGER, MLPA, AND ARRAY CGH, WITH MRNA ANALYTICS TO RESOLVE VARIANTS OF UNKNOWN SIGNIFICANCE WHEN INDICATED (24 GENES (SEQUENCING AND DELETION/DUPLICATION), EPCAM (DELETION/DUPLICATION ONLY))	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0111U	ONCOLOGY (COLON CANCER), TARGETED KRAS (CODONS 12, 13, AND 61) AND NRAS (CODONS 12, 13, AND 61) GENE ANALYSIS, UTILIZING FORMALIN-FIXED PARAFFIN-EMBEDDED TISSUE	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0113U	ONCOLOGY (PROSTATE), MEASUREMENT OF PCA3 AND TMPRSS2-ERG IN URINE AND PSA IN SERUM FOLLOWING PROSTATIC MASSAGE, BY RNA AMPLIFICATION AND FLUORESCENCE-BASED DETECTION, ALGORITHM REPORTED AS RISK SCORE	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0129U	HEREDITARY BREAST CANCER-RELATED DISORDERS (EG, HEREDITARY BREAST CANCER, HEREDITARY OVARIAN CANCER, HEREDITARY ENDOMETRIAL CANCER), GENOMIC SEQUENCE ANALYSIS AND DELETION/DUPLICATION ANALYSIS PANEL (ATM, BRCA1, BRCA2, CDH1, CHEK2, PALB2, PTEN, AND TP53)	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0131U	HEREDITARY BREAST CANCER-RELATED DISORDERS (EG, HEREDITARY BREAST CANCER, HEREDITARY OVARIAN CANCER, HEREDITARY ENDOMETRIAL CANCER), TARGETED MRNA SEQUENCE ANALYSIS PANEL (13 GENES) (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0132U	HEREDITARY OVARIAN CANCER-RELATED DISORDERS (EG, HEREDITARY BREAST CANCER, HEREDITARY OVARIAN CANCER, HEREDITARY ENDOMETRIAL CANCER), TARGETED MRNA SEQUENCE ANALYSIS PANEL (17 GENES) (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0133U	HEREDITARY PROSTATE CANCER-RELATED DISORDERS, TARGETED MRNA SEQUENCE ANALYSIS PANEL (11 GENES) (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0134U	HEREDITARY PAN CANCER (EG, HEREDITARY BREAST AND OVARIAN CANCER, HEREDITARY ENDOMETRIAL CANCER, HEREDITARY COLORECTAL CANCER), TARGETED MRNA SEQUENCE ANALYSIS PANEL (18 GENES) (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0135U	HEREDITARY GYNECOLOGICAL CANCER (EG, HEREDITARY BREAST AND OVARIAN CANCER, HEREDITARY ENDOMETRIAL CANCER, HEREDITARY COLORECTAL CANCER), TARGETED MRNA SEQUENCE ANALYSIS PANEL (12 GENES) (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0136U	ATM (ATAXIA TELANGIECTASIA MUTATED) (EG, ATAXIA TELANGIECTASIA) MRNA SEQUENCE ANALYSIS (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0137U	PALB2 (PARTNER AND LOCALIZER OF BRCA2) (EG, BREAST AND PANCREATIC CANCER) MRNA SEQUENCE ANALYSIS (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0138U	BRCA1 (BRCA1, DNA repair associated), BRCA2 (BRCA2, DNA repair associated) (e.g., hereditary breast and ovarian cancer)mRNA sequence analysis (List separately in addition to code for primary procedure)	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0153U	ONCOLOGY (BREAST), MRNA, GENE EXPRESSION PROFILING BY NEXT-GENERATION SEQUENCING OF 101 GENES, UTILIZING FORMALIN-FIXED PARAFFIN-EMBEDDED TISSUE, ALGORITHM REPORTED AS A TRIPLE NEGATIVE BREAST CANCER CLINICAL SUBTYPE(S) WITH INFORMATION ON IMMUNE CELL INVOLVEMENT	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0154U	ONCOLOGY (UROTHELIAL CANCER), RNA, ANALYSIS BY REAL-TIME RT-PCR OF THE FGFR3 (FIBROBLAST GROWTH FACTOR RECEPTOR 3) GENE ANALYSIS (IE, P.R248C (C.742C>T), P.S249C (C.746C>G), P.G370C (C.1108G>T), P.Y373C (C.1118A>G), FGFR3-TACC3V1, AND FGFR3-TACC3V3), UTILIZING FORMALIN-FIXED PARAFFIN-EMBEDDED UROTHELIAL CANCER TUMOR TISSUE, REPORTED AS FGFR GENE ALTERATION STATUS	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0155U	ONCOLOGY (BREAST CANCER), DNA, PIK3CA (PHOSPHATIDYLINOSITOL-4,5-BISPHOSPHATE 3-KINASE, CATALYTIC SUBUNIT ALPHA) (EG, BREAST CANCER) GENE ANALYSIS (IE, P.C420R, P.E542K, P.E545A, P.E545D (G.1635G>T ONLY), P.E545G, P.E545K, P.Q546E, P.Q546R, P.H1047L, P.H1047R, P.H1047Y), UTILIZING FORMALIN-FIXED PARAFFIN-EMBEDDED BREAST TUMOR TISSUE, REPORTED AS PIK3CA GENE MUTATION STATUS	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	

Codes	Code Description	Medical Mutual Commercial	Medical Mutual Commercial Criteria	Medicare Advantage	Medicare Advantage Criteria	Details/Notes
0156U	COPY NUMBER (EG, INTELLECTUAL DISABILITY, DYSMORPHOLOGY), SEQUENCE ANALYSIS	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0157U	APC (APC REGULATOR OF WNT SIGNALING PATHWAY) (EG, FAMILIAL ADENOMATOSIS POLYPOSIS (FAP)) MRNA SEQUENCE ANALYSIS (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0158U	MLH1 (MUTL HOMOLOG 1) (EG, HEREDITARY NON-POLYPOSIS COLORECTAL CANCER, LYNCH SYNDROME) MRNA SEQUENCE ANALYSIS (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0159U	MSH2 (MUTS HOMOLOG 2) (EG, HEREDITARY COLON CANCER, LYNCH SYNDROME) MRNA SEQUENCE ANALYSIS (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0160U	MSH6 (MUTS HOMOLOG 6) (EG, HEREDITARY COLON CANCER, LYNCH SYNDROME) MRNA SEQUENCE ANALYSIS (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
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 REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0162U	HEREDITARY COLON CANCER (LYNCH SYNDROME), TARGETED MRNA SEQUENCE ANALYSIS PANEL (MLH1, MSH2, MSH6, PMS2) (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
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 REQUIRED - MEDICAL POLICY	CMP200813	PRIOR AUTHORIZATION NOT REQUIRED		
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 REQUIRED - MEDICAL POLICY	CMP200813	PRIOR AUTHORIZATION NOT REQUIRED		
0169U	NUDT15 (NUDIX HYDROLASE 15) AND TPMT (THIOPURINE S-METHYLTRANSFERASE) (EG, DRUG METABOLISM) GENE ANALYSIS, COMMON VARIANTS	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0171U	TARGETED GENOMIC SEQUENCE ANALYSIS PANEL, ACUTE MYELOID LEUKEMIA, MYELODYSPLASTIC SYNDROME, AND MYELOPROLIFERATIVE NEOPLASMS, DNA ANALYSIS, 23 GENES, INTERROGATION FOR SEQUENCE VARIANTS, REARRANGEMENTS AND MINIMAL RESIDUAL DISEASE, REPORTED AS PRESENCE/ABSENCE	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0172U	ONCOLOGY (SOLID TUMOR AS INDICATED BY THE LABEL), SOMATIC MUTATION ANALYSIS OF BRCA1 (BRCA1, DNA REPAIR ASSOCIATED), BRCA2 (BRCA2, DNA REPAIR ASSOCIATED) AND ANALYSIS OF HOMOLOGOUS RECOMBINATION DEFICIENCY PATHWAYS, DNA, FORMALIN-FIXED PARAFFIN-EMBEDDED TISSUE, ALGORITHM QUANTIFYING TUMOR GENOMIC INSTABILITY SCORE	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0173U	PSYCHIATRY (IE, DEPRESSION, ANXIETY), GENOMIC ANALYSIS PANEL, INCLUDES VARIANT ANALYSIS OF 14 GENES	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0174U	ONCOLOGY (SOLID TUMOR), MASS SPECTROMETRIC 30 PROTEIN TARGETS, FORMALIN-FIXED PARAFFIN-EMBEDDED TISSUE, PROGNOSTIC AND PREDICTIVE ALGORITHM REPORTED AS LIKELY, UNLIKELY, OR UNCERTAIN BENEFIT OF 39 CHEMOTHERAPY AND TARGETED THERAPEUTIC ONCOLOGY AGENTS	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0175U	PSYCHIATRY (EG, DEPRESSION, ANXIETY), GENOMIC ANALYSIS PANEL, VARIANT ANALYSIS OF 15 GENES	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0177U	ONCOLOGY (BREAST CANCER), DNA, PIK3CA (PHOSPHATIDYLINOSITOL-4, 5-BISPHOSPHATE 3-KINASE CATALYTIC SUBUNIT ALPHA) GENE ANALYSIS OF 11 GENE VARIANTS UTILIZING PLASMA, REPORTED AS PIK3CA GENE MUTATION STATUS	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0179U	ONCOLOGY (NON-SMALL CELL LUNG CANCER), CELL-FREE DNA, TARGETED SEQUENCE ANALYSIS OF 23 GENES (SINGLE NUCLEOTIDE VARIATIONS, INSERTIONS AND DELETIONS, FUSIONS WITHOUT PRIOR KNOWLEDGE OF PARTNER/BREAKPOINT, COPY NUMBER VARIATIONS), WITH REPORT OF SIGNIFICANT MUTATION(S)	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0195U	KLF1 (KRUPPEL-LIKE FACTOR 1), TARGETED SEQUENCING (IE, EXON 13)	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	

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0205U	OPHTHALMOLOGY (AGE-RELATED MACULAR DEGENERATION), ANALYSIS OF 3 GENE VARIANTS (2 CFH GENE, 1 ARMS2 GENE), USING PCR AND MALDI-TOF, BUCCAL SWAB, REPORTED AS POSITIVE OR NEGATIVE FOR NEOVASCULAR AGE-RELATED MACULAR-DEGENERATION RISK ASSOCIATED WITH ZINC SUPPLEMENTS	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0209U	CYTOGENOMIC CONSTITUTIONAL (GENOME-WIDE) ANLYSIS, INTERROGATION OF GENOMIC REGIONS FOR COPY NUMBER, STRUCTURAL CHANGES AND AREAS OF HOMOZYGOSITY FOR CHROMOSOMAL ABNORMALITIES	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0211U	ONCOLOGY (PAN-TUMOR), DNA AND RNA BY NEXT-GENERATION SEQUENCING, UTILIZING FORMALIN-FIXED PARAFFIN-EMBEDDED TISSUE, INTERPRETATIVE REPORT FOR SINGLE NUCLEOTIDE VARIANTS, COPY NUMBER ALTERATIONS, TUMOR MUTATIONAL BURDEN, AND MICROSATELLITE INSTABILITY, WITH THERAPY ASSOCIATION	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0212U	RARE DISEASES (CONSTITUTIONAL/HERITABLE DISORDERS), WHOLE GENOME AND MITOCHONDRIAL DNA SEQUENCE ANALYSIS, INCLUDING SMALL SEQUENCE CHANGES, DELETIONS, DUPLICATIONS, SHORT TANDEM REPEAT GENE EXPANSIONS, AND VARIANTS IN NON-UNIQUELY MAPPABLE REGIONS, BLOOD OR SALIVA, IDENTIFICATION AND CATEGORIZATION OF GENETIC VARIANTS, PROBAND	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0213U	RARE DISEASES (CONSTITUTIONAL/HERITABLE DISORDERS), WHOLE GENOME AND MITOCHONDRIAL DNA SEQUENCE ANALYSIS, INCLUDING SMALL SEQUENCE CHANGES, DELETIONS, DUPLICATIONS, SHORT TANDEM REPEAT GENE EXPANSIONS, AND VARIANTS IN NON-UNIQUELY MAPPABLE REGIONS, BLOOD OR SALIVA, IDENTIFICATION AND CATEGORIZATION OF GENETIC VARIANTS, EACH COMPARATOR GENOME (EG, PARENT, SIBLING)	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0214U	RARE DISEASES (CONSTITUTIONAL/HERITABLE DISORDERS), WHOLE EXOME AND MITOCHONDRIAL DNA SEQUENCE ANALYSIS, INCLUDING SMALL SEQUENCE CHANGES, DELETIONS, DUPLICATIONS, SHORT TANDEM REPEAT GENE EXPANSIONS, AND VARIANTS IN NON-UNIQUELY MAPPABLE REGIONS, BLOOD OR SALIVA, IDENTIFICATION AND CATEGORIZATION OF GENETIC VARIANTS, PROBAND	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0215U	RARE DISEASES (CONSTITUTIONAL/HERITABLE DISORDERS), WHOLE EXOME AND MITOCHONDRIAL DNA SEQUENCE ANALYSIS, INCLUDING SMALL SEQUENCE CHANGES, DELETIONS, DUPLICATIONS, SHORT TANDEM REPEAT GENE EXPANSIONS, AND VARIANTS IN NON-UNIQUELY MAPPABLE REGIONS, BLOOD OR SALIVA, IDENTIFICATION AND CATEGORIZATION OF GENETIC VARIANTS, EACH COMPARATOR EXOME (EG, PARENT, SIBLING)	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0216U	NEUROLOGY (INHERITED ATAXIAS), GENOMIC DNA SEQUENCE ANALYSIS OF 12 COMMON GENES INCLUDING SMALL SEQUENCE CHANGES, DELETIONS, DUPLICATIONS, SHORT TANDEM REPEAT GENE EXPANSIONS, AND VARIANTS IN NON-UNIQUELY MAPPABLE REGIONS, BLOOD OR SALIVA, IDENTIFICATION AND CATEGORIZATION OF GENETIC VARIANTS	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0217U	NEUROLOGY (INHERITED ATAXIAS), GENOMIC DNA SEQUENCE ANALYSIS OF 51 GENES INCLUDING SMALL SEQUENCE CHANGES, DELETIONS, DUPLICATIONS, SHORT TANDEM REPEAT GENE EXPANSIONS, AND VARIANTS IN NON-UNIQUELY MAPPABLE REGIONS, BLOOD OR SALIVA, IDENTIFICATION AND CATEGORIZATION OF GENETIC VARIANTS	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0218U	NEUROLOGY (MUSCULAR DYSTROPHY), DMD GENE SEQUENCE ANALYSIS, INCLUDING SMALL SEQUENCE CHANGES, DELETIONS, DUPLICATIONS, AND VARIANTS IN NON-UNIQUELY MAPPABLE REGIONS, BLOOD OR SALIVA, IDENTIFICATION AND CHARACTERIZATION OF GENETIC VARIANTS	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0228U	ONCOLOGY (PROSTATE), MULTIANALYTE MOLECULAR PROFILE BY PHOTOMETRIC DETECTION OF MACROMOLECULES ADSORBED ON NANOSPONGE ARRAY SLIDES WITH MACHINE LEARNING, UTILIZING FIRST MORNING VOIDED URINE, ALGORITHM REPORTED AS LIKELIHOOD OF PROSTATE CANCER	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0229U	BCAT1 (BRANCHED CHAIN AMINO ACID TRANSAMINASE 1) OR IKZF1 (IKAROS FAMILY ZINC FINGER 1) (EG, COLORECTAL CANCER) PROMOTER METHYLATION ANALYSIS	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	

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0233U	FXN (FRATAXIN) (EG, FRIEDREICH ATAXIA), GENE ANALYSIS, INCLUDING SMALL SEQUENCE CHANGES IN EXONIC AND INTRONIC REGIONS, DELETIONS, DUPLICATIONS, SHORT TANDEM REPEAT (STR) EXPANSIONS, MOBILE ELEMENT INSERTIONS, AND VARIANTS IN NON-UNIQUELY MAPPABLE REGIONS	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0234U	MECP2 (METHYL CPG BINDING PROTEIN 2) (EG, RETT SYNDROME), FULL GENE ANALYSIS, INCLUDING SMALL SEQUENCE CHANGES IN EXONIC AND INTRONIC REGIONS, DELETIONS, DUPLICATIONS, MOBILE ELEMENT INSERTIONS AND VARIANTS IN NON-UNIQUELY MAPPABLE REGIONS	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0235U	PTEN (PHOSPHATASE AND TENSIN HOMOLOG) (EG, COWDEN SYNDROME, PTEN HAMATOMA TUMOR SYNDROME), FULL GENE ANALYSIS, INCLUDING SMALL SEQUENCE CHANGES IN EXONIC AND INTRONIC REGIONS, DELETIONS, DUPLICATIONS, MOBILE ELEMENT INSERTIONS, AND VARIANTS IN NON-UNIQUELY MAPPABLE REGIONS	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0236U	SMN1 (SURVIVAL OF MOTOR NEURON 1, TELOMERIC) AND SMN2 (SURVIVAL OF MOTOR NEURON 2, CENTROMERIC) (EG, SPINAL MUSCULAR ATROPHY) FULL GENE ANALYSIS, INCLUDING SMALL SEQUENCE CHANGES IN EXONIC AND INTRONIC REGIONS, DUPLICATIONS AND DELETIONS, AND MOBILE ELEMENT INSERTIONS	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0237U	CARDIAC ION CHANNELOPATHIES (EG, BRUGADA SYNDROME, LONG QT SYNDROME, SHORT QT SYNDROME, CATECHOLAMINERGIC POLYMORPHIC VENTRICULAR TACHYCARDIA), GENOMIC SEQUENCE ANALYSIS PANEL INCLUDING ANK2, CASQ2, CAV3, KCNE1, KCNE2, KCNH2, KCNJ2, KCNQ1, RYR2, AND SCN5A, INCLUDING SMALL SEQUENCE CHANGES IN EXONIC AND INTRONIC REGIONS, DELETIONS, DUPLICATIONS, MOBILE ELEMENT INSERTIONS, AND VARIANTS IN NON-UNIQUELY MAPPABLE REGIONS	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0238U	ONCOLOGY (LYNCH SYNDROME), GENOMIC DNA SEQUENCE ANALYSIS OF MLH1, MSH2, MSH6, PMS2, AND EPCAM, INCLUDING SMALL SEQUENCE CHANGES IN EXONIC AND INTRONIC REGIONS, DELETIONS, DUPLICATIONS, MOBILE ELEMENT INSERTIONS, AND VARIANTS IN NON-UNIQUELY MAPPABLE REGIONS	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0239U	TARGETED GENOMIC SEQUENCE ANALYSIS PANEL, SOLID ORGAN NEOPLASM, CELL-FREE DNA, ANALYSIS OF 311 OR MORE GENES, INTERROGATION FOR SEQUENCE VARIANTS, INCLUDING SUBSTITUTIONS, INSERTIONS, DELETIONS, SELECT REARRANGEMENTS, AND COPY NUMBER VARATIONS	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0242U	TARGETED GENOMIC SEQUENCE ANALYSIS PANEL, SOLID ORGAN NEOPLASM, CELL-FREE CIRCULATING DNA ANALYSIS OF 55-74 GENES, INTERROGATION FOR SEQUENCE VARIANTS, GENE COPY NUMBER AMPLIFICATIONS, AND GENE REARRANGEMENTS	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0244U	ONCOLOGY (SOLID ORGAN), DNA, COMPREHENSIVE GENOMIC PROFILING, 257 GENES, INTERROGATION FOR SINGLE-NUCLEOTIDE VARIANTS, INSERTIONS/DELETIONS, COPY NUMBER ALTERATIONS, GENE REARRANGEMENTS, TUMOR-MUTATIONAL BURDEN AND MICROSATELLITE INSTABILITY, UTILIZING FORMALIN-FIXED PARAFFIN-EMBEDDED TUMOR TISSUE	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0245U	ONCOLOGY (THYROID), MUTATION ANALYSIS OF 10 GENES AND 37 RNA FUSIONS AND EXPRESSION OF 4 mRNA MARKERS USING NEXT-GENERATION SEQUENCING, FINE NEEDLE ASPRIATE, REPORT INCLUDES ASSOCIATED RISK OF MALIGNANCY EXPRESSED AS A PERCENTAGE	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0250U	ONCOLOGY (SOLID ORGAN NEOPLASM), TARGETED GENOMIC SEQUENCE DNA ANALYSIS OF 505 GENES, INTERROGATION FOR SOMATIC ALTERATIONS (SNVs [SINGLE NUCLEOTIDE VARIANT], SMALL INSERTIONS AND DELETIONS, ONE AMPLIFICATION, AND FOUR TRANSLOCATIONS), MICROSATELLITE INSTABILITY AND TUMOR-MUTATION BURDEN	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0251U	HEPCIDIN-25, ENZYME-LINKED IMMUNOSORBENT ASSAY (ELISA), SERUM OR PLASMA	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP	
0252U	FETAL ANEUPLOIDY SHORT TANDEM-REPEAT COMPARATIVE ANALYSIS, FETAL DNA FROM PRODUCTS OF CONCEPTION, REPORTED AS NORMAL (EUPLOIDY), MONOSOMY, TRISOMY, OR PARTIAL DELETION/DUPLICATION, MOSAICISM, AND SEGMENTAL ANEUPLOIDY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP	

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0253U	REPRODUCTIVE MEDICINE (ENDOMETRIAL RECEPTIVITY ANALYSIS), RNA GENE EXPRESSION PROFILE, 238 GENES BY NEXT-GENERATION SEQUENCING, ENDOMETRIAL TISSUE, PREDICTIVE ALGORITHM REPORTED AS ENDOMETRIAL WINDOW OF IMPLANTATION (EG, PRE-RECEPTIVE, RECEPTIVE, POST-RECEPTIVE)	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0254U	REPRODUCTIVE MEDICINE (PREIMPLANTATION GENETIC ASSESSMENT), ANALYSIS OF 24 CHROMOSOMES USING EMBRYONIC DNA GENOMIC SEQUENCE ANALYSIS FOR ANEUPLOIDY, AND A MITOCHONDRIAL DNA SCORE IN EUPLOID EMBRYOS, RESULTS REPORTED AS NORMAL (EUPLOIDY), MONOSOMY, TRISOMY, OR PARTIAL DELETION/DUPLICATION, MOSAICISM, AND SEGMENTAL ANEUPLOIDY, PER EMBRYO TESTED	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0285U	ONCOLOGY, RESPONSE TO RADIATION, CELL-FREE DNA, QUANTITATIVE BRANCHED CHAIN DNA AMPLIFICATION, PLASMA, REPORTED AS A RADIATION TOXICITY SCORE	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0286U	CEP72 (CENTROSOMAL PROTEIN, 72-KDA), NUDT15 (NUDIX HYDROLASE 15) AND TPMT (THIOPURINE S-METHYLTRANSFERASE) (EG, DRUG METABOLISM) GENE ANALYSIS, COMMON VARIANTS	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0287U	ONCOLOGY (THYROID), DNA AND MRNA, NEXT-GENERATION SEQUENCING ANALYSIS OF 112 GENES, FINE NEEDLE ASPIRATE OR FORMALIN-FIXED PARAFFIN-EMBEDDED (FFPE) TISSUE, ALGORITHMIC PREDICTION OF CANCER RECURRENCE, REPORTED AS A CATEGORICAL RISK RESULT (LOW, INTERMEDIATE, HIGH)	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0288U	ONCOLOGY (LUNG), MRNA, QUANTITATIVE PCR ANALYSIS OF 11 GENES (BAG1, BRCA1, CDC6, CDK2AP1, ERBB3, FUT3, IL11, LCK, RND3, SH3BGR, WNT3A) AND 3 REFERENCE GENES (ESD, TBP, YAP1), FORMALIN-FIXED PARAFFIN-EMBEDDED (FFPE) TUMOR TISSUE, ALGORITHMIC INTERPRETATION REPORTED AS A RECURRENCE RISK SCORE	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0289U	NEUROLOGY (ALZHEIMER DISEASE), MRNA, GENE EXPRESSION PROFILING BY RNA SEQUENCING OF 24 GENES, WHOLE BLOOD, ALGORITHM REPORTED AS PREDICTIVE RISK SCORE	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0290U	PAIN MANAGEMENT, MRNA, GENE EXPRESSION PROFILING BY RNA SEQUENCING OF 36 GENES, WHOLE BLOOD, ALGORITHM REPORTED AS PREDICTIVE RISK SCORE	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0292U	PSYCHIATRY (STRESS DISORDERS), MRNA, GENE EXPRESSION PROFILING BY RNA SEQUENCING OF 72 GENES, WHOLE BLOOD, ALGORITHM REPORTED AS PREDICTIVE RISK SCORE	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0293U	PSYCHIATRY (SUICIDAL IDEATION), MRNA, GENE EXPRESSION PROFILING BY RNA SEQUENCING OF 54 GENES, WHOLE BLOOD, ALGORITHM REPORTED AS PREDICTIVE RISK SCORE	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0294U	LONGEVITY AND MORTALITY RISK, MRNA, GENE EXPRESSION PROFILING BY RNA SEQUENCING OF 18 GENES, WHOLE BLOOD, ALGORITHM REPORTED AS PREDICTIVE RISK SCORE	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0295U	ONCOLOGY (BREAST DUCTAL CARCINOMA IN SITU), PROTEIN EXPRESSION PROFILING BY IMMUNOHISTOCHEMISTRY OF 7 PROTEINS (COX2, FOXA1, HER2, KI-67, P16, PR, SIAH2), WITH 4 CLINICOPATHOLOGIC FACTORS (SIZE, AGE, MARGIN STATUS, PALPABILITY), UTILIZING FORMALIN-FIXED PARAFFIN-EMBEDDED (FFPE) TISSUE, ALGORITHM REPORTED AS A RECURRENCE RISK SCORE	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP	
0296U	ONCOLOGY (ORAL AND/OR OROPHARYNGEAL CANCER), GENE EXPRESSION PROFILING BY RNA SEQUENCING AT LEAST 20 MOLECULAR FEATURES (EG, HUMAN AND/OR MICROBIAL MRNA), SALIVA, ALGORITHM REPORTED AS POSITIVE OR NEGATIVE FOR SIGNATURE ASSOCIATED WITH MALIGNANCY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0297U	ONCOLOGY (PAN TUMOR), WHOLE GENOME SEQUENCING OF PAIRED MALIGNANT AND NORMAL DNA SPECIMENS, FRESH OR FORMALIN FIXED PARAFFIN-EMBEDDED (FFPE) TISSUE, BLOOD OR BONE MARROW, COMPARATIVE SEQUENCE ANALYSES AND VARIANT IDENTIFICATION	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0298U	ONCOLOGY (PAN TUMOR), WHOLE TRANSCRIPTOME SEQUENCING OF PAIRED MALIGNANT AND NORMAL RNA SPECIMENS, FRESH OR FORMALIN-FIXED PARAFFIN-EMBEDDED (FFPE) TISSUE, BLOOD OR BONE MARROW, COMPARATIVE SEQUENCE ANALYSES AND EXPRESSION LEVEL AND CHIMERIC TRANSCRIPT IDENTIFICATION	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	

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0299U	ONCOLOGY (PAN TUMOR), WHOLE GENOME OPTICAL GENOME MAPPING OF PAIRED MALIGNANT AND NORMAL DNA SPECIMENS, FRESH FROZEN TISSUE, BLOOD, OR BONE MARROW, COMPARATIVE STRUCTURAL VARIANT IDENTIFICATION	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0300U	ONCOLOGY (PAN TUMOR), WHOLE GENOME SEQUENCING AND OPTICAL GENOME MAPPING OF PAIRED MALIGNANT AND NORMAL DNA SPECIMENS, FRESH TISSUE, BLOOD, OR BONE MARROW, COMPARATIVE SEQUENCE ANALYSES AND VARIANT IDENTIFICATION	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0303U	HEMATOLOGY, RED BLOOD CELL (RBC) ADHESION TO ENDOTHELIAL/SUBENDOTHELIAL ADHESION MOLECULES, FUNCTIONAL ASSESSMENT, WHOLE BLOOD, WITH ALGORITHMIC ANALYSIS AND RESULT REPORTED AS AN RBC ADHESION INDEX; HYPOXIC	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP	
0304U	HEMATOLOGY, RED BLOOD CELL (RBC) ADHESION TO ENDOTHELIAL/SUBENDOTHELIAL ADHESION MOLECULES, FUNCTIONAL ASSESSMENT, WHOLE BLOOD, WITH ALGORITHMIC ANALYSIS AND RESULT REPORTED AS AN RBC ADHESION INDEX; NORMOXIC	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP	
0305U	HEMATOLOGY, RED BLOOD CELL (RBC) FUNCTIONALITY AND DEFORMITY AS A FUNCTION OF SHEAR STRESS, WHOLE BLOOD, REPORTED AS A MAXIMUM ELONGATION INDEX	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP	
0308U	CARDIOLOGY (CORONARY ARTERY DISEASE (CAD)), ANALYSIS OF 3 PROTEINS (HIGH SENSITIVITY (HS) TROPONIN, ADIPONECTIN, AND KIDNEY INJURY MOLECULE-1 (KIM-1)) WITH 3 CLINICAL PARAMETERS (AGE, SEX, HISTORY OF CARDIAC INTERVENTION), PLASMA, ALGORITHM REPORTED AS A RISK SCORE FOR OBSTRUCTIVE CAD	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0309U	CARDIOLOGY (CARDIOVASCULAR DISEASE), ANALYSIS OF 4 PROTEINS (NT-PROBNP, OSTEOPONTIN, TISSUE INHIBITOR OF METALLOPROTEINASE-1 (TIMP-1), AND KIDNEY INJURY MOLECULE-1 (KIM-1)), PLASMA, ALGORITHM REPORTED AS A RISK SCORE FOR MAJOR ADVERSE CARDIAC EVENT	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0310U	PEDIATRICS (VASCULITIS, KAWASAKI DISEASE (KD)), ANALYSIS OF 3 BIOMARKERS (NT-PROBNP, C-REACTIVE PROTEIN, AND T-UPTAKE), PLASMA, ALGORITHM REPORTED AS A RISK SCORE FOR KD	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0311U	INFECTIOUS DISEASE (BACTERIAL), QUANTITATIVE ANTIMICROBIAL SUSCEPTIBILITY REPORTED AS PHENOTYPIC MINIMUM INHIBITORY CONCENTRATION (MIC)-BASED ANTIMICROBIAL SUSCEPTIBILITY FOR EACH ORGANISM IDENTIFIED	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0312U	AUTOIMMUNE DISEASES (EG, SYSTEMIC LUPUS ERYTHEMATOSUS (SLE)), ANALYSIS OF 8 IGG AUTOANTIBODIES AND 2 CELL-BOUND COMPLEMENT ACTIVATION PRODUCTS USING ENZYME-LINKED IMMUNOSORBENT IMMUNOASSAY (ELISA), FLOW CYTOMETRY AND INDIRECT IMMUNOFLUORESCENCE, SERUM, OR PLASMA AND WHOLE BLOOD, INDIVIDUAL COMPONENTS REPORTED ALONG WITH AN ALGORITHMIC SLE-LIKELIHOOD ASSESSMENT	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0316U	BORRELIA BURGDORFERI (LYME DISEASE), OSPA PROTEIN EVALUATION, URINE	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0317U	ONCOLOGY (LUNG CANCER), FOUR-PROBE FISH (3Q29, 3P22.1, 10Q22.3, 10CEN) ASSAY, WHOLE BLOOD, PREDICTIVE ALGORITHM-GENERATED EVALUATION REPORTED AS DECREASED OR INCREASED RISK FOR LUNG CANCER	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0318U	PEDIATRICS (CONGENITAL EPIGENETIC DISORDERS), WHOLE GENOME METHYLATION ANALYSIS BY MICROARRAY FOR 50 OR MORE GENES, BLOOD	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0321U	INFECTIOUS AGENT DETECTION BY NUCLEIC ACID (DNA OR RNA), GENITOURINARY PATHOGENS, IDENTIFICATION OF 20 BACTERIAL AND FUNGAL ORGANISMS AND IDENTIFICATION OF 16 ASSOCIATED ANTIBIOTIC-RESISTANCE GENES, MULTIPLEX AMPLIFIED PROBE TECHNIQUE	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0322U	NEUROLOGY (AUTISM SPECTRUM DISORDER (ASD)), QUANTITATIVE MEASUREMENTS OF 14 ACYL CARNITINES AND MICROBIOME-DERIVED METABOLITES, LIQUID CHROMATOGRAPHY WITH TANDEM MASS SPECTROMETRY (LC-MS/MS), PLASMA, RESULTS REPORTED AS NEGATIVE OR POSITIVE FOR RISK OF METABOLIC SUBTYPES ASSOCIATED WITH ASD	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	

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0326U	TARGETED GENOMIC SEQUENCE ANALYSIS PANEL, SOLID ORGAN NEOPLASM, CELL-FREE CIRCULATING DNA ANALYSIS OF 83 OR MORE GENES, INTERROGATION FOR SEQUENCE VARIANTS, GENE COPY NUMBER AMPLIFICATIONS, GENE REARRANGEMENTS, MICROSATELLITE INSTABILITY AND TUMOR MUTATIONAL BURDEN	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED-FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0327U	FETAL ANEUPLOIDY (TRISOMY 13, 18, AND 21), DNA SEQUENCE ANALYSIS OF SELECTED REGIONS USING MATERNAL PLASMA, ALGORITHM REPORTED AS A RISK SCORE FOR EACH TRISOMY, INCLUDES SEX REPORTING, IF PERFORMED	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0329U	ONCOLOGY (NEOPLASIA), EXOME AND TRANSCRIPTOME SEQUENCE ANALYSIS FOR SEQUENCE VARIANTS, GENE COPY NUMBER AMPLIFICATIONS AND DELETIONS, GENE REARRANGEMENTS, MICROSATELLITE INSTABILITY AND TUMOR MUTATIONAL BURDEN UTILIZING DNA AND RNA FROM TUMOR WITH DNA FROM NORMAL BLOOD OR SALIVA FOR SUBTRACTION, REPORT OF CLINICALLY SIGNIFICANT MUTATION(S) WITH THERAPY ASSOCIATIONS	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0331U	ONCOLOGY (HEMATOLYMPHOID NEOPLASIA), OPTICAL GENOME MAPPING FOR COPY NUMBER ALTERATIONS AND GENE REARRANGEMENTS UTILIZING DNA FROM BLOOD OR BONE MARROW, REPORT OF CLINICALLY SIGNIFICANT ALTERATIONS	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0332U	ONCOLOGY (PAN-TUMOR), GENETIC PROFILING OF 8 DNA-REGULATORY (EPIGENETIC) MARKERS BY QUANTITATIVE POLYMERASE CHAIN REACTION (QPCR), WHOLE BLOOD, REPORTED AS A HIGH OR LOW PROBABILITY OF RESPONDING TO IMMUNE CHECKPOINT-INHIBITOR THERAPY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0333U	ONCOLOGY (LIVER), SURVEILLANCE FOR HEPATOCELLULAR CARCINOMA (HCC) IN HIGH-RISK PATIENTS, ANALYSIS OF METHYLATION PATTERNS ON CIRCULATING CELL-FREE DNA (CFDNA) PLUS MEASUREMENT OF SERUM OF AFP/AFP-L3 AND ONCOPROTEIN DES-GAMMA-CARBOXY-PROTHROMBIN (DCP), ALGORITHM REPORTED AS NORMAL OR ABNORMAL RESULT	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0335U	RARE DISEASES (CONSTITUTIONAL/HERITABLE DISORDERS), WHOLE GENOME SEQUENCE ANALYSIS, INCLUDING SMALL SEQUENCE CHANGES, COPY NUMBER VARIANTS, DELETIONS, DUPLICATIONS, MOBILE ELEMENT INSERTIONS, UNIPARENTAL DISOMY (UPD), INVERSIONS, ANEUPLOIDY, MITOCHONDRIAL GENOME SEQUENCE ANALYSIS WITH HETEROPLASMY AND LARGE DELETIONS, SHORT TANDEM REPEAT (STR) GENE EXPANSIONS, FETAL SAMPLE, IDENTIFICATION AND CATEGORIZATION OF GENETIC VARIANTS	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0336U	RARE DISEASES (CONSTITUTIONAL/HERITABLE DISORDERS), WHOLE GENOME SEQUENCE ANALYSIS, INCLUDING SMALL SEQUENCE CHANGES, COPY NUMBER VARIANTS, DELETIONS, DUPLICATIONS, MOBILE ELEMENT INSERTIONS, UNIPARENTAL DISOMY (UPD), INVERSIONS, ANEUPLOIDY, MITOCHONDRIAL GENOME SEQUENCE ANALYSIS WITH HETEROPLASMY AND LARGE DELETIONS, SHORT TANDEM REPEAT (STR) GENE EXPANSIONS, BLOOD OR SALIVA, IDENTIFICATION AND CATEGORIZATION OF GENETIC VARIANTS, EACH COMPARATOR GENOME (EG, PARENT)	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0337U	ONCOLOGY (PLASMA CELL DISORDERS AND MYELOMA), CIRCULATING PLASMA CELL IMMUNOLOGIC SELECTION, IDENTIFICATION, MORPHOLOGICAL CHARACTERIZATION, AND ENUMERATION OF PLASMA CELLS BASED ON DIFFERENTIAL CD138, CD38, CD19, AND CD45 PROTEIN BIOMARKER EXPRESSION, PERIPHERAL BLOOD	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP	
0338U	ONCOLOGY (SOLID TUMOR), CIRCULATING TUMOR CELL SELECTION, IDENTIFICATION, MORPHOLOGICAL CHARACTERIZATION, DETECTION AND ENUMERATION BASED ON DIFFERENTIAL EPCAM, CYTOKERATINS 8, 18, AND 19, AND CD45 PROTEIN BIOMARKERS, AND QUANTIFICATION OF HER2 PROTEIN BIOMARKER-EXPRESSING CELLS, PERIPHERAL BLOOD	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP	
0339U	ONCOLOGY (PROSTATE), MRNA EXPRESSION PROFILING OF HOXC6 AND DLX1, REVERSE TRANSCRIPTION POLYMERASE CHAIN REACTION (RT-PCR), FIRST-VOID URINE FOLLOWING DIGITAL RECTAL EXAMINATION, ALGORITHM REPORTED AS PROBABILITY OF HIGH-GRADE CANCER	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0340U	ONCOLOGY (PAN-CANCER), ANALYSIS OF MINIMAL RESIDUAL DISEASE (MRD) FROM PLASMA, WITH ASSAYS PERSONALIZED TO EACH PATIENT BASED ON PRIOR NEXT-GENERATION SEQUENCING OF THE PATIENTS TUMOR AND GERMLINE DNA, REPORTED AS ABSENCE OR PRESENCE OF MRD, WITH DISEASE-BURDEN CORRELATION, IF APPROPRIATE	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	

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0341U	FETAL ANEUPLOIDY DNA SEQUENCING COMPARATIVE ANALYSIS, FETAL DNA FROM PRODUCTS OF CONCEPTION, REPORTED AS NORMAL (EUPLOIDY), MONOSOMY, TRISOMY, OR PARTIAL DELETION/DUPLICATION, MOSAICISM, AND SEGMENTAL ANEUPLOID	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0342U	ONCOLOGY (PANCREATIC CANCER), MULTIPLEX IMMUNOASSAY OF C5, C4, CYSTATIN C, FACTOR B, OSTEOPROTEGERIN (OPG), GELSOLIN, IGFBP3, CA125 AND MULTIPLEX ELECTROCHEMILUMINESCENT IMMUNOASSAY (ECLIA) FOR CA19-9, SERUM, DIAGNOSTIC ALGORITHM REPORTED QUALITATIVELY AS POSITIVE, NEGATIVE, OR BORDERLINE	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP	
0343U	ONCOLOGY (PROSTATE), EXOSOME-BASED ANALYSIS OF 442 SMALL NONCODING RNAS (SNCRNAS) BY QUANTITATIVE REVERSE TRANSCRIPTION POLYMERASE CHAIN REACTION (RT-QPCR), URINE, REPORTED AS MOLECULAR EVIDENCE OF NO-, LOW-, INTERMEDIATE- OR HIGH-RISK OF PROSTATE CANCER	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0344U	HEPATOLOGY (NONALCOHOLIC FATTY LIVER DISEASE (NAFLD)), SEMIQUANTITATIVE EVALUATION OF 28 LIPID MARKERS BY LIQUID CHROMATOGRAPHY WITH TANDEM MASS SPECTROMETRY (LC-MS/MS), SERUM, REPORTED AS AT-RISK FOR NONALCOHOLIC STEATOHEPATITIS (NASH) OR NOT NASH	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0345U	PSYCHIATRY (EG, DEPRESSION, ANXIETY, ATTENTION DEFICIT HYPERACTIVITY DISORDER (ADHD)), GENOMIC ANALYSIS PANEL, VARIANT ANALYSIS OF 15 GENES, INCLUDING DELETION/DUPLICATION ANALYSIS OF CYP2D6	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0347U	DRUG METABOLISM OR PROCESSING (MULTIPLE CONDITIONS), WHOLE BLOOD OR BUCCAL SPECIMEN, DNA ANALYSIS, 16 GENE REPORT, WITH VARIANT ANALYSIS AND REPORTED PHENOTYPES	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0348U	DRUG METABOLISM OR PROCESSING (MULTIPLE CONDITIONS), WHOLE BLOOD OR BUCCAL SPECIMEN, DNA ANALYSIS, 25 GENE REPORT, WITH VARIANT ANALYSIS AND REPORTED PHENOTYPES	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0349U	DRUG METABOLISM OR PROCESSING (MULTIPLE CONDITIONS), WHOLE BLOOD OR BUCCAL SPECIMEN, DNA ANALYSIS, 27 GENE REPORT, WITH VARIANT ANALYSIS, INCLUDING REPORTED PHENOTYPES AND IMPACTED GENE-DRUG INTERACTIONS	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0350U	DRUG METABOLISM OR PROCESSING (MULTIPLE CONDITIONS), WHOLE BLOOD OR BUCCAL SPECIMEN, DNA ANALYSIS, 27 GENE REPORT, WITH VARIANT ANALYSIS AND REPORTED PHENOTYPES	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0356U	ONCOLOGY (OROPHARYNGEAL OR ANAL), EVALUATION OF 17 DNA BIOMARKERS USING DROPLET DIGITAL PCR (DDPCR), CELL-FREE DNA, ALGORITHM REPORTED AS A PROGNOSTIC RISK SCORE FOR CANCER RECURRENCE	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0358U	BIOELECTRICAL IMPEDANCE ANALYSIS WHOLE BODY COMPOSITION ASSESSMENT, WITH INTERPRETATION AND REPORT NEUROLOGY (MILD COGNITIVE IMPAIRMENT), ANALYSIS OF B-AMYLOID 1-42 AND 1-40, CHEMILUMINESCENCE ENZYME IMMUNOASSAY, CEREBRAL SPINAL FLUID, REPORTED AS POSITIVE, LIKELY POSITIVE, OR NEGATIVE	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP	
0359U	ONCOLOGY (PROSTATE CANCER), ANALYSIS OF ALL PROSTATE-SPECIFIC ANTIGEN (PSA) STRUCTURAL ISOFORMS BY PHASE SEPARATION AND IMMUNOASSAY, PLASMA, ALGORITHM REPORTS RISK OF CANCER	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0360U	ONCOLOGY (LUNG), ENZYME-LINKED IMMUNOSORBENT ASSAY (ELISA) OF 7 AUTOANTIBODIES (P53, NY-ESO-1, CAGE, GBU4-5, SOX2, MAGE A4, AND HUD), PLASMA, ALGORITHM REPORTED AS A CATEGORICAL RESULT FOR RISK OF MALIGNANCY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0362U	ONCOLOGY (PAPILLARY THYROID CANCER), GENE-EXPRESSION PROFILING VIA TARGETED HYBRID CAPTURE-ENRICHMENT RNA SEQUENCING OF 82 CONTENT GENES AND 10 HOUSEKEEPING GENES, FINE NEEDLE ASPIRATE OR FORMALIN-FIXED PARAFFIN-EMBEDDED (FFPE) TISSUE, ALGORITHM REPORTED AS ONE OF THREE MOLECULAR SUBTYPES	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0363U	ONCOLOGY (UROTHELIAL), MRNA, GENE-EXPRESSION PROFILING BY REAL-TIME QUANTITATIVE PCR OF 5 GENES (MDK, HOXA13, CDC2 (CDK1), IGFBP5, AND CXCR2), UTILIZING URINE, ALGORITHM INCORPORATES AGE, SEX, SMOKING HISTORY, AND MACROHEMATURIA FREQUENCY, REPORTED AS A RISK SCORE FOR HAVING UROTHELIAL CARCINOMA	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	

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0364U	ONCOLOGY (HEMATOLYMPHOID NEOPLASM), GENOMIC SEQUENCE ANALYSIS USING MULTIPLEX (PCR) AND NEXT-GENERATION SEQUENCING WITH ALGORITHM, QUANTIFICATION OF DOMINANT CLONAL SEQUENCE(S), REPORTED AS PRESENCE OR ABSENCE OF MINIMAL RESIDUAL DISEASE (MRD) WITH QUANTITATION OF DISEASE BURDEN, WHEN APPROPRIATE	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201923	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0365U	ONCOLOGY (BLADDER), ANALYSIS OF 10 PROTEIN BIOMARKERS (A1AT, ANG, APOE, CA9, IL8, MMP9, MMP10, PAI1, SDC1 AND VEGFA) BY IMMUNOASSAYS, URINE, ALGORITHM REPORTED AS A PROBABILITY OF BLADDER CANCER	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0366U	ONCOLOGY (BLADDER), ANALYSIS OF 10 PROTEIN BIOMARKERS (A1AT, ANG, APOE, CA9, IL8, MMP9, MMP10, PAI1, SDC1 AND VEGFA) BY IMMUNOASSAYS, URINE, ALGORITHM REPORTED AS A PROBABILITY OF RECURRENT BLADDER CANCER	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0367U	ONCOLOGY (BLADDER), ANALYSIS OF 10 PROTEIN BIOMARKERS (A1AT, ANG, APOE, CA9, IL8, MMP9, MMP10, PAI1, SDC1 AND VEGFA) BY IMMUNOASSAYS, URINE, DIAGNOSTIC ALGORITHM REPORTED AS A RISK SCORE FOR PROBABILITY OF RAPID RECURRENCE OF RECURRENT OR PERSISTENT CANCER FOLLOWING TRANSURETHRAL RESECTION	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0368U	ONCOLOGY (COLORECTAL CANCER), EVALUATION FOR MUTATIONS OF APC, BRAF, CTNNB1, KRAS, NRAS, PIK3CA, SMAD4, AND TP53, AND METHYLATION MARKERS (MYO1G, KCNQ5, C9ORF50, FLI1, CLIP4, ZNF132 AND TWIST1), MULTIPLEX QUANTITATIVE POLYMERASE CHAIN REACTION (QPCR), CIRCULATING CELL-FREE DNA (CFDNA), PLASMA, REPORT OF RISK SCORE FOR ADVANCED ADENOMA OR COLORECTAL CANCER	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0375U	ONCOLOGY (OVARIAN), BIOCHEMICAL ASSAYS OF 7 PROTEINS (FOLLICLE STIMULATING HORMONE, HUMAN EPIDIDYMIS PROTEIN 4, APOLIPOPROTEIN A-1, TRANSFERRIN, BETA-2 MACROGLOBULIN, PREALBUMIN (IE, TRANSTHYRETIN), AND CANCER ANTIGEN 125), ALGORITHM REPORTED AS OVARIAN CANCER RISK SCORE	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0376U	ONCOLOGY (PROSTATE CANCER), IMAGE ANALYSIS OF AT LEAST 128 HISTOLOGIC FEATURES AND CLINICAL FACTORS, PROGNOSTIC ALGORITHM DETERMINING THE RISK OF DISTANT METASTASES, AND PROSTATE CANCER-SPECIFIC MORTALITY, INCLUDES PREDICTIVE ALGORITHM TO ANDROGEN DEPRIVATION-THERAPY RESPONSE, IF APPROPRIATE	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP	
0377U	CARDIOVASCULAR DISEASE, QUANTIFICATION OF ADVANCED SERUM OR PLASMA LIPOPROTEIN PROFILE, BY NUCLEAR MAGNETIC RESONANCE (NMR) SPECTROMETRY WITH REPORT OF A LIPOPROTEIN PROFILE (INCLUDING 23 VARIABLES)	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP	
0378U	RFC1 (REPLICATION FACTOR C SUBUNIT 1), REPEAT EXPANSION VARIANT ANALYSIS BY TRADITIONAL AND REPEAT-PRIMED PCR, BLOOD, SALIVA, OR BUCCAL SWAB	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0380U	DRUG METABOLISM (ADVERSE DRUG REACTIONS AND DRUG RESPONSE), TARGETED SEQUENCE ANALYSIS, 20 GENE VARIANTS AND CYP2D6 DELETION OR DUPLICATION ANALYSIS WITH REPORTED GENOTYPE AND PHENOTYPE	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0381U	MAPLE SYRUP URINE DISEASE MONITORING BY PATIENT-COLLECTED BLOOD CARD SAMPLE, QUANTITATIVE MEASUREMENT OF ALLO-ISOLEUCINE, LEUCINE, ISOLEUCINE, AND VALINE, LIQUID CHROMATOGRAPHY WITH TANDEM MASS SPECTROMETRY (LC-MS/MS)	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED-FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0384U	NEPHROLOGY (CHRONIC KIDNEY DISEASE), CARBOXYMETHYLLYSINE, METHYLGLYOXAL HYDROIMIDAZOLONE, AND CARBOXYETHYL LYSINE BY LIQUID CHROMATOGRAPHY WITH TANDEM MASS SPECTROMETRY (LC-MS/MS) AND HBA1C AND ESTIMATED GLOMERULAR FILTRATION RATE (GFR), WITH RISK SCORE REPORTED FOR PREDICTIVE PROGRESSION TO HIGH-STAGE KIDNEY DISEASE	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0385U	NEPHROLOGY (CHRONIC KIDNEY DISEASE), APOLIPOPROTEIN A4 (APOA4), CD5 ANTIGEN-LIKE (CD5L), AND INSULIN-LIKE GROWTH FACTOR BINDING PROTEIN 3 (IGFBP3) BY ENZYME-LINKED IMMUNOASSAY (ELISA), PLASMA, ALGORITHM COMBINING RESULTS WITH HDL, ESTIMATED GLOMERULAR FILTRATION RATE (GFR) AND CLINICAL DATA REPORTED AS A RISK SCORE FOR DEVELOPING DIABETIC KIDNEY DISEASE	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0387U	ONCOLOGY (MELANOMA), AUTOPHAGY AND BECLIN 1 REGULATOR 1 (AMBRA1) AND LORICRIN (AMLO) BY IMMUNOHISTOCHEMISTRY, FORMALIN-FIXED PARAFFIN-EMBEDDED (FFPE) TISSUE, REPORT FOR RISK OF PROGRESSION	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP	

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0388U	ONCOLOGY (NON-SMALL CELL LUNG CANCER), NEXT-GENERATION SEQUENCING WITH IDENTIFICATION OF SINGLE NUCLEOTIDE VARIANTS, COPY NUMBER VARIANTS, INSERTIONS AND DELETIONS, AND STRUCTURAL VARIANTS IN 37 CANCER-RELATED GENES, PLASMA, WITH REPORT FOR ALTERATION DETECTION	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0389U	PEDIATRIC FEBRILE ILLNESS (KAWASAKI DISEASE (KD)), INTERFERON ALPHA-INDUCIBLE PROTEIN 27 (IFI27) AND MAST CELL-EXPRESSED MEMBRANE PROTEIN 1 (MCEMP1), RNA, USING REVERSE TRANSCRIPTION POLYMERASE CHAIN REACTION (RT-QPCR), BLOOD, REPORTED AS A RISK SCORE FOR KD	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0390U	OBSTETRICS (PREECLAMPSIA), KINASE INSERT DOMAIN RECEPTOR (KDR), ENDOGLIN (ENG), AND RETINOL-BINDING PROTEIN 4 (RBP4), BY IMMUNOASSAY, SERUM, ALGORITHM REPORTED AS A RISK SCORE	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP	
0391U	ONCOLOGY (SOLID TUMOR), DNA AND RNA BY NEXT-GENERATION SEQUENCING, UTILIZING FORMALIN-FIXED PARAFFIN-EMBEDDED (FFPE) TISSUE, 437 GENES, INTERPRETIVE REPORT FOR SINGLE NUCLEOTIDE VARIANTS, SPLICE-SITE VARIANTS, INSERTIONS/DELETIONS, COPY NUMBER ALTERATIONS, GENE FUSIONS, TUMOR MUTATIONAL BURDEN, AND MICROSATELLITE INSTABILITY, WITH ALGORITHM QUANTIFYING IMMUNOTHERAPY RESPONSE SCORE	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0392U	DRUG METABOLISM (DEPRESSION, ANXIETY, ATTENTION DEFICIT HYPERACTIVITY DISORDER (ADHD)), GENE-DRUG INTERACTIONS, VARIANT ANALYSIS OF 16 GENES, INCLUDING DELETION/DUPLICATION ANALYSIS OF CYP2D6, REPORTED AS IMPACT OF GENE-DRUG INTERACTION FOR EACH DRUG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0393U	NEUROLOGY (EG, PARKINSON DISEASE, DEMENTIA WITH LEWY BODIES), CEREBROSPINAL FLUID (CSF), DETECTION OF MISFOLDED ?-SYNUCLEIN PROTEIN BY SEED AMPLIFICATION ASSAY, QUALITATIVE	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP	
0394U	PERFLUOROALKYL SUBSTANCES (PFAS) (EG, PERFLUOROOCTANOIC ACID, PERFLUOROOCTANE SULFONIC ACID), 16 PFAS COMPOUNDS BY LIQUID CHROMATOGRAPHY WITH TANDEM MASS SPECTROMETRY (LC-MS/MS), PLASMA OR SERUM, QUANTITATIVE	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP	
0395U	ONCOLOGY (LUNG), MULTI-OMICS (MICROBIAL DNA BY SHOTGUN NEXT-GENERATION SEQUENCING AND CARCINOEMBRYONIC ANTIGEN AND OSTEOPONTIN BY IMMUNOASSAY), PLASMA, ALGORITHM REPORTED AS MALIGNANCY RISK FOR LUNG NODULES IN EARLY-STAGE DISEASE	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0398T	ENDOSCOPIC RETROGRADE CHOLANGIOPANCREATOGRAPHY (ERCP), WITH OPTICAL ENDOMICROSCOPY (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP202308	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0398U	GASTROENTEROLOGY (BARRETT ESOPHAGUS), P16, RUNX3, HPP1, AND FBN1 DNA METHYLATION ANALYSIS USING PCR, FORMALIN-FIXED PARAFFIN-EMBEDDED (FFPE) TISSUE, ALGORITHM REPORTED AS RISK SCORE FOR PROGRESSION TO HIGH-GRADE DYSPLASIA OR CANCER	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0399U	NEUROLOGY (CEREBRAL FOLATE DEFICIENCY), SERUM, DETECTION OF ANTI-HUMAN FOLATE RECEPTOR IGG-BINDING ANTIBODY AND BLOCKING AUTOANTIBODIES BY ENZYME-LINKED IMMUNOASSAY (ELISA), QUALITATIVE, AND BLOCKING AUTOANTIBODIES, USING A FUNCTIONAL BLOCKING ASSAY FOR IGG OR IGM, QUANTITATIVE, REPORTED AS POSITIVE OR NOT DETECTED	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP	
0400U	OBSTETRICS (EXPANDED CARRIER SCREENING), 145 GENES BY NEXT-GENERATION SEQUENCING, FRAGMENT ANALYSIS AND MULTIPLEX LIGATION-DEPENDENT PROBE AMPLIFICATION, DNA, REPORTED AS CARRIER POSITIVE OR NEGATIVE	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0401U	CARDIOLOGY (CORONARY HEART DISEASE (CAD)), 9 GENES (12 VARIANTS), TARGETED VARIANT GENOTYPING, BLOOD, SALIVA, OR BUCCAL SWAB, ALGORITHM REPORTED AS A GENETIC RISK SCORE FOR A CORONARY EVENT	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0403U	ONCOLOGY (PROSTATE), MRNA, GENE EXPRESSION PROFILING OF 18 GENES, FIRST-CATCH POST-DIGITAL RECTAL EXAMINATION URINE (OR PROCESSED FIRST-CATCH URINE), ALGORITHM REPORTED AS PERCENTAGE OF LIKELIHOOD OF DETECTING CLINICALLY SIGNIFICANT PROSTATE CANCER	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0404U	ONCOLOGY (BREAST), SEMIQUANTITATIVE MEASUREMENT OF THYMIDINE KINASE ACTIVITY BY IMMUNOASSAY, SERUM, RESULTS REPORTED AS RISK OF DISEASE PROGRESSION	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP	

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0405U	ONCOLOGY (PANCREATIC), 59 METHYLATION HAPLOTYPE BLOCK MARKERS, NEXT-GENERATION SEQUENCING, PLASMA, REPORTED AS CANCER SIGNAL DETECTED OR NOT DETECTED	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0406U	ONCOLOGY (LUNG), FLOW CYTOMETRY, SPUTUM, 5 MARKERS (MESO-TETRA (4-CARBOXYPHENYL) PORPHYRIN (TCPP), CD206, CD66B, CD3, CD19), ALGORITHM REPORTED AS LIKELIHOOD OF LUNG CANCER	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP	
0407U	NEPHROLOGY (DIABETIC CHRONIC KIDNEY DISEASE (CKD)), MULTIPLEX ELECTROCHEMILUMINESCENT IMMUNOASSAY (ECLIA) OF SOLUBLE TUMOR NECROSIS FACTOR RECEPTOR 1 (STNFR1), SOLUBLE TUMOR NECROSIS RECEPTOR 2 (STNFR2), AND KIDNEY INJURY MOLECULE 1 (KIM-1) COMBINED WITH CLINICAL DATA, PLASMA, ALGORITHM REPORTED AS RISK FOR PROGRESSIVE DECLINE IN KIDNEY FUNCTION	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0409U	ONCOLOGY (SOLID TUMOR), DNA (80 GENES) AND RNA (36 GENES), BY NEXT-GENERATION SEQUENCING FROM PLASMA, INCLUDING SINGLE NUCLEOTIDE VARIANTS, INSERTIONS/DELETIONS, COPY NUMBER ALTERATIONS, MICROSATELLITE INSTABILITY, AND FUSIONS, REPORT SHOWING IDENTIFIED MUTATIONS WITH CLINICAL ACTIONABILITY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0410U	ONCOLOGY (PANCREATIC), DNA, WHOLE GENOME SEQUENCING WITH 5-HYDROXYMETHYLCYTOSINE ENRICHMENT, WHOLE BLOOD OR PLASMA, ALGORITHM REPORTED AS CANCER DETECTED OR NOT DETECTED	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0411U	PSYCHIATRY (EG, DEPRESSION, ANXIETY, ATTENTION DEFICIT HYPERACTIVITY DISORDER (ADHD)), GENOMIC ANALYSIS PANEL, VARIANT ANALYSIS OF 15 GENES, INCLUDING DELETION/DUPLICATION ANALYSIS OF CYP2D6	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0412U	BETA AMYLOID, AB42/40 RATIO, IMMUNOPRECIPITATION WITH QUANTITATION BY LIQUID CHROMATOGRAPHY WITH TANDEM MASS SPECTROMETRY (LC-MS/MS) AND QUALITATIVE APOE ISOFORM-SPECIFIC PROTEOTYPING, PLASMA COMBINED WITH AGE, ALGORITHM REPORTED AS PRESENCE OR ABSENCE OF BRAIN AMYLOID PATHOLOGY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0413U	ONCOLOGY (HEMATOLYMPHOID NEOPLASM), OPTICAL GENOME MAPPING FOR COPY NUMBER ALTERATIONS, ANEUPLOIDY, AND BALANCED/COMPLEX STRUCTURAL REARRANGEMENTS, DNA FROM BLOOD OR BONE MARROW, REPORT OF CLINICALLY SIGNIFICANT ALTERATIONS	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0414U	ONCOLOGY (LUNG), AUGMENTATIVE ALGORITHMIC ANALYSIS OF DIGITIZED WHOLE SLIDE IMAGING FOR 8 GENES (ALK, BRAF, EGFR, ERBB2, MET, NTRK1-3, RET, ROS1), AND KRAS G12C AND PD-L1, IF PERFORMED, FORMALIN-FIXED PARAFFIN-EMBEDDED (FFPE) TISSUE, REPORTED AS POSITIVE OR NEGATIVE FOR EACH BIOMARKER	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP	
0415U	CARDIOVASCULAR DISEASE (ACUTE CORONARY SYNDROME (ACS)), IL-16, FAS, FASLIGAND, HGF, CTACK, EOTAXIN, AND MCP-3 BY IMMUNOASSAY COMBINED WITH AGE, SEX, FAMILY HISTORY, AND PERSONAL HISTORY OF DIABETES, BLOOD, ALGORITHM REPORTED AS A 5-YEAR (DELETED RISK) SCORE FOR ACS	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0417U	RARE DISEASES (CONSTITUTIONAL/HERITABLE DISORDERS), WHOLE MITOCHONDRIAL GENOME SEQUENCE WITH HETEROPLASMY DETECTION AND DELETION ANALYSIS, NUCLEAR-ENCODED MITOCHONDRIAL GENE ANALYSIS OF 335 NUCLEAR GENES, INCLUDING SEQUENCE CHANGES, DELETIONS, INSERTIONS, AND COPY NUMBER VARIANTS ANALYSIS, BLOOD OR SALIVA, IDENTIFICATION AND CATEGORIZATION OF MITOCHONDRIAL DISORDERÂASSOCIATED GENETIC VARIANTS	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0418U	ONCOLOGY (BREAST), AUGMENTATIVE ALGORITHMIC ANALYSIS OF DIGITIZED WHOLE SLIDE IMAGING OF 8 HISTOLOGIC AND IMMUNOHISTOCHEMICAL FEATURES, REPORTED AS A RECURRENCE SCORE	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP	
0419U	NEUROPSYCHIATRY (EG, DEPRESSION, ANXIETY), GENOMIC SEQUENCE ANALYSIS PANEL, VARIANT ANALYSIS OF 13 GENES, SALIVA OR BUCCAL SWAB, REPORT OF EACH GENE PHENOTYPE	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0420U	ONCOLOGY (UROTHELIAL), MRNA EXPRESSION PROFILING BY REAL-TIME QUANTITATIVE PCR OF MDK, HOXA13, CDC2, IGFBP5, AND CXCR2 IN COMBINATION WITH DROPLET DIGITAL PCR (DDPCR) ANALYSIS OF 6 SINGLE-NUCLEOTIDE POLYMORPHISMS (SNPS) GENES TERT AND FGFR3, URINE, ALGORITHM REPORTED AS A RISK SCORE FOR UROTHELIAL CARCINOMA	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	

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0421U	ONCOLOGY (COLORECTAL) SCREENING, QUANTITATIVE REAL-TIME TARGET AND SIGNAL AMPLIFICATION OF 8 RNA MARKERS (GAPDH, SMAD4, ACY1, AREG, CDH1, KRAS, TNFRSF10B, EGLN2) AND FECAL HEMOGLOBIN, ALGORITHM REPORTED AS A POSITIVE OR NEGATIVE FOR COLORECTAL CANCER RISK	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0422U	ONCOLOGY (PAN-SOLID TUMOR), ANALYSIS OF DNA BIOMARKER RESPONSE TO ANTI-CANCER THERAPY USING CELL-FREE CIRCULATING DNA, BIOMARKER COMPARISON TO A PREVIOUS BASELINE PRE-TREATMENT CELL-FREE CIRCULATING DNA ANALYSIS USING NEXT-GENERATION SEQUENCING, ALGORITHM REPORTED AS A QUANTITATIVE CHANGE FROM BASELINE, INCLUDING SPECIFIC ALTERATIONS, IF APPROPRIATE	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0423U	PSYCHIATRY (EG, DEPRESSION, ANXIETY), GENOMIC ANALYSIS PANEL, INCLUDING VARIANT ANALYSIS OF 26 GENES, BUCCAL SWAB, REPORT INCLUDING METABOLIZER STATUS AND RISK OF DRUG TOXICITY BY CONDITION	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0424U	ONCOLOGY (PROSTATE), EXOSOME-BASED ANALYSIS OF 53 SMALL NONCODING RNAS (SNCRNAS) BY QUANTITATIVE REVERSE TRANSCRIPTION POLYMERASE CHAIN REACTION (RT-QPCR), URINE, REPORTED AS NO MOLECULAR EVIDENCE, LOW-, MODERATE- OR ELEVATED-RISK OF PROSTATE CANCER	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0425U	GENOME (EG, UNEXPLAINED CONSTITUTIONAL OR HERITABLE DISORDER OR SYNDROME), RAPID SEQUENCE ANALYSIS, EACH COMPARATOR GENOME (EG, PARENTS, SIBLINGS)	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0426U	GENOME (EG, UNEXPLAINED CONSTITUTIONAL OR HERITABLE DISORDER OR SYNDROME), ULTRA-RAPID SEQUENCE ANALYSIS	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0428U	ONCOLOGY (BREAST), TARGETED HYBRID-CAPTURE GENOMIC SEQUENCE ANALYSIS PANEL, CIRCULATING TUMOR DNA (CTDNA) ANALYSIS OF 56 OR MORE GENES, INTERROGATION FOR SEQUENCE VARIANTS, GENE COPY NUMBER AMPLIFICATIONS, GENE REARRANGEMENTS, MICROSATELLITE INSTABILITY, AND TUMOR MUTATION BURDEN	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0433U	ONCOLOGY (PROSTATE), 5 DNA REGULATORY MARKERS BY QUANTITATIVE PCR, WHOLE BLOOD, ALGORITHM, INCLUDING PROSTATE-SPECIFIC ANTIGEN, REPORTED AS LIKELIHOOD OF CANCER	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0434U	DRUG METABOLISM (ADVERSE DRUG REACTIONS AND DRUG RESPONSE), GENOMIC ANALYSIS PANEL, VARIANT ANALYSIS OF 25 GENES WITH REPORTED PHENOTYPES	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0435U	ONCOLOGY, CHEMOTHERAPEUTIC DRUG CYTOTOXICITY ASSAY OF CANCER STEM CELLS (CSCS), FROM CULTURED CSCS AND PRIMARY TUMOR CELLS, CATEGORICAL DRUG RESPONSE REPORTED BASED ON CYTOTOXICITY PERCENTAGE OBSERVED, MINIMUM OF 14 DRUGS OR DRUG COMBINATIONS	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED-FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0436U	ONCOLOGY (LUNG), PLASMA ANALYSIS OF 388 PROTEINS, USING APTAMER-BASED PROTEOMICS TECHNOLOGY, PREDICTIVE ALGORITHM REPORTED AS CLINICAL BENEFIT FROM IMMUNE CHECKPOINT INHIBITOR THERAPY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0437U	PSYCHIATRY (ANXIETY DISORDERS), MRNA, GENE EXPRESSION PROFILING BY RNA SEQUENCING OF 15 BIOMARKERS, WHOLE BLOOD, ALGORITHM REPORTED AS PREDICTIVE RISK SCORE	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0438U	DRUG METABOLISM (ADVERSE DRUG REACTIONS AND DRUG RESPONSE), BUCCAL SPECIMEN, GENE-DRUG INTERACTIONS, VARIANT ANALYSIS OF 33 GENES, INCLUDING DELETION/DUPLICATION ANALYSIS OF CYP2D6, INCLUDING REPORTED PHENOTYPES AND IMPACTED GENE-DRUG INTERACTIONS	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0439U	CARDIOLOGY (CORONARY HEART DISEASE (CHD)), DNA, ANALYSIS OF 5 SINGLE-NUCLEOTIDE POLYMORPHISMS (SNPS) (RS11716050 (LOC105376934), RS6560711 (WDR37), RS3735222 (SCIN/LOC107986769), RS6820447 (INTERGENIC), AND RS9638144 (ESYT2)) AND 3 DNA METHYLATION MARKERS (CG00300879 (TRANSCRIPTION START SITE {TSS200} OF CNKSR1), CG09552548 (INTERGENIC), AND CG14789911 (BODY OF SPATC1L)), QPCR AND DIGITAL PCR, WHOLE BLOOD, ALGORITHM REPORTED AS A 4-TIERED RISK SCORE FOR A 3-YEAR RISK OF SYMPTOMATIC CHD	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	

Codes	Code Description	Medical Mutual Commercial	Medical Mutual Commercial Criteria	Medicare Advantage	Medicare Advantage Criteria	Details/Notes
0440U	CARDIOLOGY (CORONARY HEART DISEASE (CHD)), DNA, ANALYSIS OF 10 SINGLE-NUCLEOTIDE POLYMORPHISMS (SNPS) (RS710987 (LINC010019), RS1333048 (CDKN2B-AS1), RS12129789 (KCND3), RS942317 (KTN1-AS1), RS1441433 (PPP3CA), RS2869675 (PREX1), RS4639796 (ZBTB41), RS4376434 (LINC00972), RS12714414 (TMEM18), AND RS7585056 (TMEM18)) AND 6 DNA METHYLATION MARKERS (CG03725309 (SARS1), CG12586707 (CXCL1, CG04988978 (MPO), CG17901584 (DHCR24-DT), CG21161138 (AHRR), AND CG12655112 (EHD4)), QPCR AND DIGITAL PCR, WHOLE BLOOD, ALGORITHM REPORTED AS DETECTED OR NOT DETECTED FOR CHD	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0444U	ONCOLOGY (SOLID ORGAN NEOPLASIA), TARGETED GENOMIC SEQUENCE ANALYSIS PANEL OF 361 GENES, INTERROGATION FOR GENE FUSIONS, TRANSLOCATIONS, OR OTHER REARRANGEMENTS, USING DNA FROM FORMALIN-FIXED PARAFFIN-EMBEDDED (FFPE) TUMOR TISSUE, REPORT OF CLINICALLY SIGNIFICANT VARIANT(S)	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0448U	ONCOLOGY (LUNG AND COLON CANCER), DNA, QUALITATIVE, NEXT-GENERATION SEQUENCING DETECTION OF SINGLE-NUCLEOTIDE VARIANTS AND DELETIONS IN EGFR AND KRAS GENES, FORMALIN-FIXED PARAFFIN-EMBEDDED (FFPE) SOLID TUMOR SAMPLES, REPORTED AS PRESENCE OR ABSENCE OF TARGETED MUTATION(S), WITH RECOMMENDED THERAPEUTIC OPTIONS	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0449T	INSERTION OF AQUEOUS DRAINAGE DEVICE, WITHOUT EXTRAOCULAR RESERVOIR, INTERNAL APPROACH, INTO THE SUBCONJUNCTIVAL SPACE; INITIAL DEVICE	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201721	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0449U	CARRIER SCREENING FOR SEVERE INHERITED CONDITIONS (EG, CYSTIC FIBROSIS, SPINAL MUSCULAR ATROPHY, BETA HEMOGLOBINOPATHIES (INCLUDING SICKLE CELL DISEASE), ALPHA THALASSEMIA), REGARDLESS OF RACE OR SELF-IDENTIFIED ANCESTRY, GENOMIC SEQUENCE ANALYSIS PANEL, MUST INCLUDE ANALYSIS OF 5 GENES (CFTR, SMN1, HBB, HBA1, HBA2)	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0450T	INSERTION OF AQUEOUS DRAINAGE DEVICE, WITHOUT EXTRAOCULAR RESERVOIR, INTERNAL APPROACH, INTO THE SUBCONJUNCTIVAL SPACE; EACH ADDITIONAL DEVICE (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201721	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0452U	Oncology (bladder), methylated PENK DNA detection by linear target enrichment-quantitative methylation-specific real-time PCR (LTE-qMSP), urine, reported as likelihood of bladder cancer	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0453U	Oncology (colorectal cancer), cell free DNA (cfDNA), methylation based quantitative PCR assay (SEPTIN9, IKZF1, BCAT1,Septin9-2, VAV3, BCAN), plasma, reported as presence or absence of circulating tumor DNA (ctDNA)	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0454U	Rare diseases (constitutional/heritable disorders), identification of copy number variations, inversions, insertions, translocations, and other structural variants by optical genome mapping(For additional PLA codes with identical clinical descriptor, see 0260U, 0264U. See Appendix O or the most current listing on the AMA CPT website to determine appropriate code assignment)	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0456U	Autoimmune (rheumatoid arthritis), next-generation sequencing (NGS), gene expression testing of 19 genes, whole blood, with analysis of anti cyclic citrullinated peptides (CCP) levels, combined with sex, patient global assessment, and body mass index (BMI), algorithm reported as a score that predicts nonresponse to tumor necrosis factor inhibitor (TNFi) therapy	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0460U	Oncology, whole blood or buccal, DNA single-nucleotide polymorphism (SNP) genotyping by real-time PCR of 24 genes, with variant analysis and reported phenotypes	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0461U	Oncology, pharmacogenomic analysis of single-nucleotide polymorphism (SNP) genotyping by real-time PCR of 24 genes, whole blood or buccal swab, with variant analysis, including impacted gene-drug interactions and reported phenotypes	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	

Codes	Code Description	Medical Mutual Commercial	Medical Mutual Commercial Criteria	Medicare Advantage	Medicare Advantage Criteria	Details/Notes
0463U	Oncology (cervix), mRNA gene expression profiling of 14 biomarkers (E6 and E7 of the highest-risk human papillomavirus [HPV] types 16, 18, 31, 33, 45, 52, 58), by real-time nucleic acid sequence-based amplification (NASBA), exo- or endocervical epithelial cells, algorithm reported as positive or negative for increased risk of cervical dysplasia or cancer for each biomarker	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0465U	Oncology (urothelial carcinoma),DNA, quantitative methylation specific PCR of 2 genes (ONECUT2, VIM), algorithmic analysis reported as positive or negative	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0466U	Cardiology (coronary artery disease [CAD]), DNA, genome wide association studies (564856 single-nucleotide polymorphisms [SNPs], targeted variant genotyping), patient lifestyle and clinical data, buccal swab, algorithm reported as polygenic risk to acquired heart disease	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0467U	Oncology (bladder), DNA, next generation sequencing (NGS) of 60 genes and whole genome aneuploidy, urine, algorithms reported as minimal residual disease (MRD) status positive or negative and quantitative disease burden	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0468U	HEPATOLOGY (NONALCOHOLIC STEATOHEPATITIS (NASH)), MIR-34A-5P, ALPHA 2-MACROGLOBULIN, YKL40, HBA1C, SERUM AND WHOLE BLOOD, ALGORITHM REPORTED AS A SINGLE SCORE FOR NASH ACTIVITY AND FIBROSIS	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0469U	Rare diseases (constitutional/heritable disorders), whole genome sequence analysis for chromosomal abnormalities, copy number variants,duplications/deletions, inversions, unbalanced translocations, regions of homozygosity (ROH), inheritance pattern that indicate uniparental disomy (UPD), and aneuploidy, fetal sample (amniotic fluid, chorionic villus sample, or products of conception), identification and categorization of genetic variants, diagnostic report of fetal results based on phenotype with maternal sample and paternal sample, if performed, as comparators and/or maternal cell contamination	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0471U	Oncology (colorectal cancer), qualitative real-time PCR of 35 variants of KRAS and NRAS genes (exons 2, 3, 4), formalin fixed paraffin-embedded (FFPE), predictive, identification of detected mutations	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0473U	Oncology (solid tumor), next generation sequencing (NGS) of DNA from formalin-fixed paraffin embedded (FFPE) tissue with comparative sequence analysis from a matched normal specimen (blood or saliva), 648 genes, interrogation for sequence variants, insertion and deletion alterations, copy number variants, rearrangements, microsatellite instability, and tumor-mutation burden	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0474U	Hereditary pan-cancer (eg, hereditary sarcomas, hereditary endocrine tumors, hereditary neuroendocrine tumors, hereditary cutaneous melanoma), genomic sequence analysis panel of 88 genes with 20 duplications/deletions using next generation sequencing (NGS), Sanger sequencing, blood or saliva, reported as positive or negative for germline variants, each gene	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0475U	Hereditary prostate cancer related disorders, genomic sequence analysis panel using next-generation sequencing (NGS), Sanger sequencing, multiplex ligation-dependent probe amplification (MLPA), and array comparative genomic hybridization (CGH), evaluation of 23 genes and duplications/deletions when indicated, pathologic mutations reported with a genetic risk score for prostate cancer	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0476U	Drug metabolism, psychiatry (eg, major depressive disorder, general anxiety disorder, attention deficit hyperactivity disorder [ADHD], schizophrenia), whole blood, buccal swab, and pharmacogenomic genotyping of 14 genes and CYP2D6 copy number variant analysis and reported phenotypes	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED-FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0477U	Drug metabolism, psychiatry (eg, major depressive disorder, general anxiety disorder, attention deficit hyperactivity disorder [ADHD], schizophrenia), whole blood, buccal swab, and pharmacogenomic genotyping of 14 genes and CYP2D6 copy number variant analysis, including impacted gene-drug interactions and reported phenotypes	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED-FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0478U	Oncology (non-small cell lung cancer), DNA and RNA, digital PCR analysis of 9 genes (EGFR, KRAS, BRAF, ALK, ROS1, RET, NTRK 1/2/3, ERBB2, and MET) in formalin-fixed paraffin-embedded (FFPE) tissue, interrogation for single-nucleotide variants, insertions/deletions, gene rearrangements, and reported as actionable detected variants for therapy selection	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED-FOLLOW MEDICARE COVERAGE CRITERIA	CMS	

Codes	Code Description	Medical Mutual Commercial	Medical Mutual Commercial Criteria	Medicare Advantage	Medicare Advantage Criteria	Details/Notes
0481U	IDH1 (isocitrate dehydrogenase 1 [NADP+]), IDH2 (isocitrate dehydrogenase 2 [NADP+]), and TERT (telomerase reverse transcriptase) promoter (eg, central nervous system [CNS] tumors), next-generation sequencing (single-nucleotide variants [SNV], deletions, and insertions)	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED-FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0485U	Oncology (solid tumor), cell-free DNA and RNA by next-generation sequencing, interpretative report for germline mutations, clonal hematopoiesis of indeterminate potential, and tumor-derived single-nucleotide variants, small insertions/deletions, copy number alterations, fusions, microsatellite instability, and tumor mutational burden	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED-FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0486U	Oncology (pan-solid tumor), next generation sequencing analysis of tumor methylation markers present in cell-free circulating tumor DNA, algorithm reported as quantitative measurement of methylation as a correlate of tumor fraction	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED-FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0487U	Oncology (solid tumor), cell-free circulating DNA, targeted genomic sequence analysis panel of 84 genes, interrogation for sequence variants, aneuploidy corrected gene copy number amplifications and losses, gene rearrangements, and microsatellite instability	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED-FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0488U	OBSTETRICS (FETAL ANTIGEN NONINVASIVE PRENATAL TEST), CELL-FREE DNA SEQUENCE ANALYSIS FOR DETECTION OF FETAL PRESENCE OR ABSENCE OF 1 OR MORE OF THE RH, C, C, D, E, DUFFY (FYA), OR KELL (K) ANTIGEN IN ALLOIMMUNIZED PREGNANCIES, REPORTED AS SELECTED ANTIGEN(S) DETECTED OR NOT DETECTED	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED-FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0489U	OBSTETRICS (SINGLE-GENE NONINVASIVE PRENATAL TEST), CELL-FREE DNA SEQUENCE ANALYSIS OF 1 OR MORE TARGETS (EG, CFTR, SMN1, HBB, HBA1, HBA2) TO IDENTIFY PATERNALLY INHERITED PATHOGENIC VARIANTS, AND RELATIVE MUTATION-DOSAGE ANALYSIS BASED ON MOLECULAR COUNTS TO DETERMINE FETAL INHERITANCE OF MATERNAL MUTATION, ALGORITHM REPORTED AS A FETAL RISK SCORE FOR THE CONDITION (EG, CYSTIC FIBROSIS, SPINAL MUSCULAR ATROPHY, BETA HEMOGLOBINOPATHIES (INCLUDING SICKLE CELL DISEASE), ALPHA THALASSEMIA)	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED-FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0490U	Oncology (cutaneous or uveal melanoma), circulating tumor cell selection, morphological characterization and enumeration based on differential CD146, high molecular–weight melanoma associated antigen, CD34 and CD45 protein biomarkers, peripheral blood	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED-FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0491U	Oncology (solid tumor), circulating tumor cell selection, morphological characterization and enumeration based on differential epithelial cell adhesion molecule (EpCAM), cytokeratins 8, 18, and 19, CD45 protein biomarkers, and quantification of estrogen receptor (ER) protein biomarker– expressing cells, peripheral blood	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED-FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0492U	Oncology (solid tumor), circulating tumor cell selection, morphological characterization and enumeration based on differential epithelial cell adhesion molecule (EpCAM), cytokeratins 8, 18, and 19, CD45 protein biomarkers, and quantification of PD-L1 protein biomarker–expressing cells, peripheral blood	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED-FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0493U	Transplantation medicine, quantification of donor-derived cell-free DNA (cfDNA) using next generation sequencing, plasma, reported as percentage of donor derived cell-free DNA	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED-FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0494U	Red blood cell antigen (fetal RhD gene analysis), next-generation sequencing of circulating cell-free DNA (cfDNA) of blood in pregnant individuals known to be RhD negative, reported as positive or negative	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED-FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0495U	Oncology (prostate), analysis of circulating plasma proteins (tPSA, fPSA, KLK2, PSP94, and GDF15), germline polygenic risk score (60 variants), clinical information (age, family history of prostate cancer, prior negative prostate biopsy), algorithm reported as risk of likelihood of detecting clinically significant prostate cancer	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED-FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0496U	Oncology (colorectal), cell-free DNA, 8 genes for mutations, 7 genes for methylation by real-time RT-PCR, and 4 proteins by enzyme-linked immunosorbent assay, blood, reported positive or negative for colorectal cancer or advanced adenoma risk	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED-FOLLOW MEDICARE COVERAGE CRITERIA	CMS	

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0497U	ONCOLOGY (PROSTATE), MRNA GENE-EXPRESSION PROFILING BY REAL-TIME RT-PCR OF 6 GENES (FOXM1, MCM3, MTUS1, TTC21B, ALAS1, AND PPP2CA), UTILIZING FORMALIN-FIXED PARAFFIN-EMBEDDED (FFPE) TISSUE, ALGORITHM REPORTED AS A RISK SCORE FOR PROSTATE CANCER	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED-FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0498U	Oncology (colorectal), next generation sequencing for mutation detection in 43 genes and methylation pattern in 45 genes, blood, and formalin-fixed paraffin-embedded (FFPE) tissue, report of variants and methylation pattern with interpretation	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED-FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0499U	Oncology (colorectal and lung), DNA from formalin-fixed paraffin embedded (FFPE) tissue, next generation sequencing of 8 genes (NRAS, EGFR, CTNNB1, PIK3CA, APC, BRAF, KRAS, and TP53), mutation detection	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED-FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0500U	Autoinflammatory disease (VEXAS syndrome), DNA, UBA1 gene mutations, targeted variant analysis (M41T, M41V, M41L, c.118-2A>C, c.118-1G>C, c.118-9_118-2del, S56F, S621C)	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED-FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0501U	Oncology (colorectal), blood, quantitative measurement of cell free DNA (cfDNA)	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED-FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0506U	Gastroenterology (Barrett's esophagus), esophageal cells, DNA methylation analysis by next-generation sequencing of at least 89 differentially methylated genomic regions, algorithm reported as likelihood for Barrett's esophagus	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED-FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0507U	Oncology (ovarian), DNA, whole genome sequencing with 5- hydroxymethylcytosine (5hmC) enrichment, using whole blood or plasma, algorithm reported as cancer detected or not detected	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED-FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0508U	Transplantation medicine, quantification of donor-derived cell-free DNA using 40 single nucleotide polymorphisms (SNPs), plasma, and urine, initial evaluation reported as percentage of donor-derived cell free DNA with risk for active rejection	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED-FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0509U	Transplantation medicine, quantification of donor-derived cell-free DNA using up to 12 single-nucleotide polymorphisms (SNPs) previously identified, plasma, reported as percentage of donor-derived cell-free DNA with risk for active rejection	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED-FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0510U	Oncology (pancreatic cancer), augmentative algorithmic analysis of 16 genes from previously sequenced RNA whole transcriptome data, reported as probability of predicted molecular subtype	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED-FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0511U	Oncology (solid tumor), tumor cell culture in 3D microenvironment, 36 or more drug panel, reported as tumor-response prediction for each drug	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED-FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0512U	Oncology (prostate), augmentative algorithmic analysis of digitized whole-slide imaging of histologic features for microsatellite instability (MSI) status, formalin-fixed paraffin-embedded (FFPE) tissue, reported as increased or decreased probability of MSI-high (MSI-H)	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED-FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0513U	Oncology (prostate), augmentative algorithmic analysis of digitized whole-slide imaging of histologic features for microsatellite instability (MSI) and homologous recombination deficiency (HRD) status, formalin-fixed paraffin-embedded (FFPE) tissue, reported as increased or decreased probability of each biomarker	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED-FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0516U	Drug metabolism, whole blood, pharmacogenomic genotyping of 40 genes and CYP2D6 copy number variant analysis, reported as metabolizer status	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201303	PRIOR AUTHORIZATION REQUIRED-FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0524T	ENDOVENOUS CATHETER DIRECTED CHEMICAL ABLATION WITH BALLOON ISOLATION OF INCOMPETENT EXTREMITY VEIN, OPEN OR PERCUTANEOUS, INCLUDING ALL VASCULAR ACCESS, CATHETER MANIPULATION, DIAGNOSTIC IMAGING, IMAGING GUIDANCE AND MONITORING	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
0532U	RARE DISEASES (CONSTITUTIONAL DISEASE/HEREDITARY DISORDERS), RAPID WHOLE GENOME AND MITOCHONDRIAL DNA SEQUENCING FOR SINGLE-NUCLEOTIDE VARIANTS, INSERTIONS/DELETIONS, COPY NUMBER VARIATIONS, PERIPHERAL BLOOD, BUFFY COAT, SALIVA, BUCCAL OR TISSUE SAMPLE, RESULTS REPORTED AS POSITIVE OR NEGATIVE	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP 201303 Genetic Testing and Genetic Counseling General Policy	PRIOR AUTHORIZATION REQUIRED-FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0533U	DRUG METABOLISM (ADVERSE DRUG REACTIONS AND DRUG RESPONSE), GENOTYPING OF 16 GENES (IE, ABCG2, CYP2B6, CYP2C9, CYP2C19, CYP2C, CYP2D6, CYP3A5, CYP4F2, DPYD, G6PD, GGCX, NUDT15, SLCO1B1, TPMT, UGT1A1, VKORC1), REPORTED AS METABOLIZER STATUS AND TRANSPORTER FUNCTION	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP 201303 Genetic Testing and Genetic Counseling General Policy	PRIOR AUTHORIZATION REQUIRED-FOLLOW MEDICARE COVERAGE CRITERIA	CMS	

Codes	Code Description	Medical Mutual Commercial	Medical Mutual Commercial Criteria	Medicare Advantage	Medicare Advantage Criteria	Details/Notes
0534U	ONCOLOGY (PROSTATE), MICRORNA, SINGLE-NUCLEOTIDE POLYMORPHISMS (SNPS) ANALYSIS BY RT-PCR OF 32 VARIANTS, USING BUCCAL SWAB, ALGORITHM REPORTED AS A RISK SCORE	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP 201303 Genetic Testing and Genetic Counseling General Policy	PRIOR AUTHORIZATION REQUIRED-FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0536U	RED BLOOD CELL ANTIGEN (FETAL RHD), PCR ANALYSIS OF EXON 4 OF RHD GENE AND HOUSEKEEPING CONTROL GENE GAPDH FROM WHOLE BLOOD IN PREGNANT INDIVIDUALS AT 10+ WEEKS GESTATION KNOWN TO BE RHD NEGATIVE, REPORTED AS FETAL RHD STATUS	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP 201303 Genetic Testing and Genetic Counseling General Policy	PRIOR AUTHORIZATION REQUIRED-FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0537U	ONCOLOGY (COLORECTAL CANCER), ANALYSIS OF CELL-FREE DNA FOR EPIGENOMIC PATTERNS, NEXT-GENERATION SEQUENCING, >2500 DIFFERENTIALLY METHYLATED REGIONS (DMRS), PLASMA, ALGORITHM REPORTED AS POSITIVE OR NEGATIVE	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP 201303 Genetic Testing and Genetic Counseling General Policy	PRIOR AUTHORIZATION REQUIRED-FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0538U	ONCOLOGY (SOLID TUMOR), NEXT-GENERATION TARGETED SEQUENCING ANALYSIS, FORMALIN-FIXED PARAFFIN-EMBEDDED (FFPE) TUMOR TISSUE, DNA ANALYSIS OF 600 GENES, INTERROGATION FOR SINGLE-NUCLEOTIDE VARIANTS, INSERTIONS/DELETIONS, GENE REARRANGEMENTS, AND COPY NUMBER ALTERATIONS, MICROSATELLITE INSTABILITY, TUMOR MUTATION BURDEN, REPORTED AS ACTIONABLE VARIANT	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP 201303 Genetic Testing and Genetic Counseling General Policy	PRIOR AUTHORIZATION REQUIRED-FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0539U	ONCOLOGY (SOLID TUMOR), CELL-FREE CIRCULATING TUMOR DNA (CTDNA), 152 GENES, NEXT-GENERATION SEQUENCING, INTERROGATION FOR SINGLE-NUCLEOTIDE VARIANTS, INSERTIONS/DELETIONS, GENE REARRANGEMENTS, COPY NUMBER ALTERATIONS, AND MICROSATELLITE INSTABILITY, USING WHOLE-BLOOD SAMPLES, MUTATIONS WITH CLINICAL ACTIONABILITY REPORTED AS ACTIONABLE VARIANT	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP 201303 Genetic Testing and Genetic Counseling General Policy	PRIOR AUTHORIZATION REQUIRED-FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0540U	TRANSPLANTATION MEDICINE, QUANTIFICATION OF DONOR-DERIVED CELL-FREE DNA USING NEXT-GENERATION SEQUENCING ANALYSIS OF PLASMA, REPORTED AS PERCENTAGE OF DONOR-DERIVED CELL-FREE DNA TO DETERMINE PROBABILITY OF REJECTION	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP 201303 Genetic Testing and Genetic Counseling General Policy	PRIOR AUTHORIZATION REQUIRED-FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0543U	ONCOLOGY (SOLID TUMOR), NEXT-GENERATION SEQUENCING OF DNA FROM FORMALIN-FIXED PARAFFIN-EMBEDDED (FFPE) TISSUE OF 517 GENES, INTERROGATION FOR SINGLE-NUCLEOTIDE VARIANTS, MULTI-NUCLEOTIDE VARIANTS, INSERTIONS AND DELETIONS FROM DNA, FUSIONS IN 24 GENES AND SPLICE VARIANTS IN 1 GENE FROM RNA, AND TUMOR MUTATION BURDEN	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP 201303 Genetic Testing and Genetic Counseling General Policy	PRIOR AUTHORIZATION REQUIRED-FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0544U	NEPHROLOGY (TRANSPLANT MONITORING), 48 VARIANTS BY DIGITAL PCR, USING CELL-FREE DNA FROM PLASMA, DONOR-DERIVED CELL-FREE DNA, PERCENTAGE REPORTED AS RISK FOR REJECTION	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP 201303 Genetic Testing and Genetic Counseling General Policy	PRIOR AUTHORIZATION REQUIRED-FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0549U	ONCOLOGY (UROTHELIAL), DNA, QUANTITATIVE METHYLATED REAL-TIME PCR OF TRNA-CYS, SIM2, AND NKX1-1, USING URINE, DIAGNOSTIC ALGORITHM REPORTED AS A PROBABILITY INDEX FOR BLADDER CANCER AND/OR UPPER TRACT UROTHELIAL CARCINOMA (UTUC)	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP 201303 Genetic Testing and Genetic Counseling General Policy	PRIOR AUTHORIZATION REQUIRED-FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0552T	LOWER LEVEL LASER THERAPY, DYNAMIC PHOTONIC AND DYNAMIC THERMOKINETIC ENERGIES, PROVIDED BY A PHYSICIAN OR OTHER QUALIFIED HEALTH CARE PROFESSIONAL	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP202206	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP	
0556T	BONE STRENGTH AND FRACTURE RISK USING FINITE ELEMENT ANALYSIS OF FUNCTIONAL DATA, AND BONE-MINERAL DENSITY, UTILIZING DATA FROM A COMPUTED TOMOGRAPHY SCAN; ASSESSMENT OF BONE STRENGTH AND FRACTURE RISK AND BONE MINERAL DENSITY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY (See Notes)	CMP94022	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	Prior authorization required if conducted more frequently than every 2 years. See Corporate Medical Policy.
0656T	VETEBRAL BODY TETHERING, ANTERIOR; UP TO 7 VERTEBRAL SEGMENTS	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP202013	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
0657T	VETEBRAL BODY TETHERING, ANTERIOR; 8 OR MORE VERTEBRAL SEGMENTS	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP202013	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
0667T	DONOR HYSTERECTOMY (INCLUDING COLD PRESERVATION); RECIPIENT UTERUS ALLOGRAFT TRANSPLANTATION FROM CADAVER OR LIVING DONOR	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201721, CMP202406	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
0671T	INSERTION OF ANTERIOR SEGMENT AQUEOUS DRAINAGE DEVICE INTO THE TRABECULAR MESHWORK, WITHOUT EXTERNAL RESERVOIR, AND WITHOUT CONCOMITANT CATARACT REMOVAL, ONE OR MORE	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201721	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0795T	TRANSCATHETER INSERTION OF PERMANENT DUAL-CHAMBER LEADLESS PACEMAKER, INCLUDING IMAGING GUIDANCE (EG, FLUOROSCOPY, VENOUS ULTRASOUND, RIGHT ATRIAL ANGIOGRAPHY, RIGHT VENTRICULOGRAPHY, FEMORAL VENOGRAPHY) AND DEVICE EVALUATION (EG, INTERROGATION OR PROGRAMMING), WHEN PERFORMED; COMPLETE SYSTEM (IE, RIGHT ATRIAL AND RIGHT VENTRICULAR PACEMAKER COMPONENTS)	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP 202504	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	

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0796T	RIGHT ATRIAL PACEMAKER COMPONENT (WHEN AN EXISTING RIGHT VENTRICULAR SINGLE LEADLESS PACEMAKER EXISTS TO CREATE A DUAL-CHAMBER LEADLESS PACEMAKER SYSTEM)	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP 202504	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
0797T	RIGHT VENTRICULAR PACEMAKER COMPONENT (WHEN PART OF A DUAL-CHAMBER LEADLESS PACEMAKER SYSTEM)	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP 202504	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
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 REQUIRED - MEDICAL POLICY	CMP 202504	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
0799T	RIGHT ATRIAL PACEMAKER COMPONENT	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP 202504	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
0800T	RIGHT VENTRICULAR PACEMAKER COMPONENT (WHEN PART OF A DUAL-CHAMBER LEADLESS PACEMAKER SYSTEM)	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP 202504	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
0801T	TRANSCATHETER REMOVAL AND REPLACEMENT OF PERMANENT DUAL-CHAMBER LEADLESS PACEMAKER, INCLUDING IMAGING GUIDANCE (EG, FLUOROSCOPY, VENOUS ULTRASOUND, RIGHT ATRIAL ANGIOGRAPHY, RIGHT VENTRICULOGRAPHY, FEMORAL VENOGRAPHY) AND DEVICE EVALUATION (EG, INTERROGATION OR PROGRAMMING), WHEN PERFORMED; DUAL-CHAMBER SYSTEM (IE, RIGHT ATRIAL AND RIGHT VENTRICULAR PACEMAKER COMPONENTS)	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP 202504	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
0802T	RIGHT ATRIAL PACEMAKER COMPONENT	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP 202504	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
0803T	RIGHT VENTRICULAR PACEMAKER COMPONENT (WHEN PART OF A DUAL-CHAMBER LEADLESS PACEMAKER SYSTEM)	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP 202504	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
0804T	PROGRAMMING DEVICE EVALUATION (IN PERSON) WITH ITERATIVE ADJUSTMENT OF IMPLANTABLE DEVICE TO TEST THE FUNCTION OF DEVICE AND TO SELECT OPTIMAL PERMANENT PROGRAMMED VALUES, WITH ANALYSIS, REVIEW, AND REPORT, BY A PHYSICIAN OR OTHER QUALIFIED HEALTH CARE PROFESSIONAL, LEADLESS PACEMAKER SYSTEM IN DUAL CARDIAC CHAMBERS	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP 202504	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
0823T	TRANSCATHETER INSERTION OF PERMANENT SINGLE-CHAMBER LEADLESS PACEMAKER, RIGHT ATRIAL, INCLUDING IMAGING GUIDANCE (EG, FLUOROSCOPY, VENOUS ULTRASOUND, RIGHT ATRIAL ANGIOGRAPHY AND/OR RIGHT VENTRICULOGRAPHY, FEMORAL VENOGRAPHY, CAVOGRAPHY) AND DEVICE EVALUATION (EG, INTERROGATION OR PROGRAMMING), WHEN PERFORMED	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP 202504	PRIOR AUTHORIZATION REQUIRED-FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0824T	TRANSCATHETER REMOVAL OF PERMANENT SINGLE-CHAMBER LEADLESS PACEMAKER, RIGHT ATRIAL, INCLUDING IMAGING GUIDANCE (EG, FLUOROSCOPY, VENOUS ULTRASOUND, RIGHT ATRIAL ANGIOGRAPHY AND/OR RIGHT VENTRICULOGRAPHY, FEMORAL VENOGRAPHY, CAVOGRAPHY), WHEN PERFORMED	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP 202504	PRIOR AUTHORIZATION REQUIRED-FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0825T	TRANSCATHETER REMOVAL AND REPLACEMENT OF PERMANENT SINGLE-CHAMBER LEADLESS PACEMAKER, RIGHT ATRIAL, INCLUDING IMAGING GUIDANCE (EG, FLUOROSCOPY, VENOUS ULTRASOUND, RIGHT ATRIAL ANGIOGRAPHY AND/OR RIGHT VENTRICULOGRAPHY, FEMORAL VENOGRAPHY, CAVOGRAPHY) AND DEVICE EVALUATION (EG, INTERROGATION OR PROGRAMMING), WHEN PERFORMED	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP 202504	PRIOR AUTHORIZATION REQUIRED-FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0826T	PROGRAMMING DEVICE EVALUATION (IN PERSON) WITH ITERATIVE ADJUSTMENT OF THE IMPLANTABLE DEVICE TO TEST THE FUNCTION OF THE DEVICE AND SELECT OPTIMAL PERMANENT PROGRAMMED VALUES WITH ANALYSIS, REVIEW AND REPORT BY A PHYSICIAN OR OTHER QUALIFIED HEALTH CARE PROFESSIONAL, LEADLESS PACEMAKER SYSTEM IN SINGLE-CARDIAC CHAMBER	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP202504	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
A0430	FIXED WING AIR TRANSPORT	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP200231	PRIOR AUTHORIZATION REQUIRED-FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
A0431	AMBULANCE SERVICE, CONVENTIONAL AIR SVC, TRANSPORT, ONE WAY (ROTARY WING)	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP200231	PRIOR AUTHORIZATION REQUIRED-FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
A0435	FIXED WING AIR TRANSPORT MILEAGE	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP200231	PRIOR AUTHORIZATION REQUIRED-FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
A0436	ROTARY WING AIR TRANSPORT MILEAGE	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP200231	PRIOR AUTHORIZATION REQUIRED-FOLLOW MEDICARE COVERAGE CRITERIA	CMS	

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A2001	INNOVAMATRIX AC, PER SQ CM	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP 200233	PRIOR AUTHORIZATION NOT REQUIRED		
A2020	AC5 ADVANCED WOUND SYSTEM (AC5)	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP 200233	PRIOR AUTHORIZATION NOT REQUIRED		
A2026	RESTRATA MINIMATRIX, 5 MG	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP 200233	PRIOR AUTHORIZATION NOT REQUIRED		
A2030	MIRO3D FIBERS, PER MG	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP 200233	PRIOR AUTHORIZATION NOT REQUIRED		
A2031	MIRODRY WOUND MATRIX, PER SQ CM	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP 200233	PRIOR AUTHORIZATION NOT REQUIRED		
A2032	MYRIAD MATRIX, PER SQ CM	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP 200233	PRIOR AUTHORIZATION NOT REQUIRED		
A4100	SKIN SUBSTITUTE, FDA CLEARED AS A DEVICE, NOT OTHERWISE SPECIFIED	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP200233	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP	
A4238	SUPPLY ALLOWANCE FOR ADJUNCTIVE CONTINUOUS GLUCOSE MONITOR (CGM), INCLUDES ALL SUPPLIES AND ACCESSORIES, 1 MONTH SUPPLY = 1 UNIT OF SERVICE	PRIOR AUTHORIZATION REQUIRED	CMP200117	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
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 REQUIRED - MEDICAL POLICY	CMP200117	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
A4290	SACRAL NERVE STIMULATION TEST LEAD, EACH	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
A4600	SLEEVE FOR INTERMITTENT LIMB COMPRESSION DEVICE, REPLACEMENT ONLY, EACH	PRIOR AUTHORIZATION **NOT** REQUIRED	None	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
A4633	REPLACEMENT BULB/LAMP FOR ULTRAVIOLET LIGHT THERAPY SYSTEM, EACH	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP94057	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP	
A7002	TUBING, USED WITH SUCTION PUMP, EACH	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP2014-A	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
A7025	HIGH FREQUENCY CHEST WALL OSCILLATION SYSTEM VEST, REPLACEMENT FOR USE WITH PATIENT OWNED EQUIPMENT, EACH	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP200508	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
A7026	HIGH FREQUENCY CHEST WALL OSCILLATION SYSTEM HOSE, REPLACEMENT FOR USE WITH PATIENT OWNED EQUIPMENT, EACH	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP200508	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
A7047	ORAL INTERFACE USED WITH RESPIRATORY SUCTION PUMP, EACH	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP2014-A	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
A9276	SENSOR; INVASIVE (E.G., SUBCUTANEOUS), DISPOSABLE, FOR USE WITH NON-DURABLE MEDICAL EQUIPMENT INTERSTITIAL CONTINUOUS GLUCOSE MONITORING SYSTEM, ONE UNIT = 1 DAY SUPPLY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP200117	NON-COVERED		
A9277	TRANSMITTER; EXTERNAL, FOR USE WITH NON-DURABLE MEDICAL EQUIPMENT INTERSTITIAL CONTINUOUS GLUCOSE MONITORING SYSTEM	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP200117	NON-COVERED		
A9278	RECEIVER (MONITOR); EXTERNAL, FOR USE WITH NON-DURABLE MEDICAL EQUIPMENT INTERSTITIAL CONTINUOUS GLUCOSE MONITORING SYSTEM	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP200117	NON-COVERED		
A9300	EXERCISE EQUIPMENT	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP2016-B	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP	
C1605	Pacemaker, leadless, dual chamber (right atrial and right ventricular implantable components), rate-responsive, including all necessary components for implantation	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP 202504	PRIOR AUTHORIZATION REQUIRED-FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
C1783	OCULAR IMPLANT, AQUEOUS DRAINAGE ASSIST DEVICE	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201721	PRIOR AUTHORIZATION NOT REQUIRED		
C9784	GASTRIC RESTRICTIVE PROCEDURE, ENDOSCOPIC SLEEVE GASTROPLASTY, WITH ESOPHAGOGASTRODUODENOSCOPY AND INTRALUMINAL TUBE INSERTION, IF PERFORMED, INCLUDING ALL SYSTEM AND TISSUE ANCHORING COMPONENTS	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP94030	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP	
C9785	ENDOSCOPIC OUTLET REDUCTION, GASTRIC POUCH APPLICATION, WITH ENDOSCOPY AND INTRALUMINAL TUBE INSERTION, IF PERFORMED, INCLUDING ALL SYSTEM AND TISSUE ANCHORING COMPONENTS	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP94030	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP	
D7951	SINUS AUGMENTATION WITH BONE OR BONE SUBSTITUTES	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201929	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
E0193	POWERED AIR FLOTATION BED (LOW AIR LOSS THERAPY)	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
E0194	AIR FLUIDIZED BED	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
E0196	GEL PRESSURE MATTRESS	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	

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E0197	AIR PRESSURE PAD FOR MATTRESS, STANDARD MATTRESS LENGTH AND WIDTH	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
E0372	POWERED AIR OVERLAY FOR MATTRESS, STANDARD MATTRESS LENGTH AND WIDTH	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
E0445	OXIMETER DEVICE FOR MEASURING BLOOD OXYGEN LEVELS NON\INVASIVELY	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
E0446	TOPICAL OXYGEN DELIVERY SYSTEM, NOT OTHERWISE SPECIFIED, INCLUDES ALL SUPPLIES AND ACCESSORIES	PRIOR AUTHORIZATION **NOT** REQUIRED	None	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	Prior authorization required for Medicare Advantage only.
E0466	HOME VENTILATOR, ANY TYPE, USED WITH NON-INVASIVE INTERFACE, (E.G., MASK, CHEST SHELL)	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
E0467	HOME VENTILATOR, MULTI-FUNCTION RESPIRATORY DEVICE, ALSO PERFORMS ANY OR ALL OF THE ADDITIONAL FUNCTIONS OF OXYGEN CONCENTRATION, DRUG NEBULIZATION, ASPIRATION, AND COUGH STIMULATION, INCLUDES ALL ACCESSORIES, COMPONENTS AND SUPPLIES FOR ALL FUNCTIONS	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
E0468	HOME VENTILATOR, DUAL-FUNCTION RESPIRATORY DEVICE, ALSO PERFORMS ADDITIONAL FUNCTION OF COUGH STIMULATION, INCLUDES ALL ACCESSORIES, COMPONENTS AND SUPPLIES FOR ALL FUNCTIONS	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
E0482	COUGH STIMULATING DEVICE, ALTERNATING POSITIVE AND NEGATIVE AIRWAY PRESSURE	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
E0483	HIGH FREQUENCY CHEST WALL OSCILLATION SYSTEM, INCLUDES ALL ACCESSORIES AND SUPPLIES, EACH	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP200508	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
E0485	ORAL DEVICE/APPLIANCE USED TO REDUCE UPPER AIRWAY COLLAPSIBILITY, ADJUSTABLE OR NON-ADJUSTABLE, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
E0617	EXTERNAL DEFIBRILLATOR WITH INTEGRATED ELECTROCARDIOGRAM ANALYSIS	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201617	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
E0638	STANDING FRAME/TABLE SYSTEM, ONE POSITION (EG, UPRIGHT, SUPINE OR PRONE STANDER), ANY SIZE INCLUDING PEDIATRIC, WITH OR WITHOUT WHEELS	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
E0641	STANDING FRAME/TABLE SYSTEM, MULTI POSITION (E.G.THREE WAY STANDER),ANY SIZE INCLUDING PEDIATRIC, WITH OR WITHOUT WHEELS	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
E0642	STANDING FRAME/TABLE SYSTEM, MULTI POSITION (E.G.THREE WAY STANDER),ANY SIZE INCLUDING PEDIATRIC, WITH OR WITHOUT WHEELS	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
E0652	PNEUMATIC COMPRESSOR, SEGMENTAL HOME MODEL WITH CALIBRATED GRADIENT PRESSURE (MAY BE COVERED ON SOME NATIONAL CONTRACTS)	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
E0655	NON\SEGMENTAL PNEUMATIC APPLIANCE FOR USE WITH PNEUMATIC COMPRESSOR, HALF ARM (MAY BE COVERED UNDER SOME NATIONAL CONTRACTS)	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
E0666	NON\SEGMENTAL PNEUMATIC APPLIANCE FOR USE WITH PNEUMATIC COMPRESSOR, HALF LEG (MAY BE COVERED UNDER SOME NATIONAL CONTRACTS)	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
E0667	SEGMENTAL PNEUMATIC APPLIANCE FOR USE WITH PNEUMATIC COMPRESSOR, FULL LEG (MAY BE COVERED UNDER SOME NATIONAL CONTRACTS)	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
E0668	SEGMENTAL PNEUMATIC APPLIANCE FOR USE WITH PNEUMATIC COMPRESSOR, FULL ARM (MAY BE COVERED UNDER SOME NATIONAL CONTRACTS)	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
E0669	SEGMENTAL PNEUMATIC APPLIANCE FOR USE WITH PNEUMATIC COMPRESSOR, HALF LEG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
E0670	SEGMENTAL PNEUMATIC APPLIANCE FOR USE WITH PNEUMATIC COMPRESSOR, INTEGRATED, 2 FULL LEGS AND TRUNK	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
E0671	SEGMENTAL GRADIENT PRESSURE PNEUMATIC APPLIANCE, FULL LEG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
E0675	PNEUMATIC COMPRESSION DEVICE, HIGH PRESSURE, RAPID INFLATION/DEFLATION CYCLE, FOR ARTERIAL INSUFFICIENCY (UNILATERAL OR BILATERAL SYSTEM)	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
E0691	ULTRAVIOLET LIGHT THERAPY SYSTEM, INCLUDES BULBS/LAMPS, TIMER AND EYE PROTECTION; TREATMENT AREA 2 SQUARE FEET OR LESS	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP94057	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
E0692	ULTRAVIOLET LIGHT THERAPY SYSTEM PANEL, INCLUDES BULBS/LAMPS, TIMER AND EYE PROTECTION, 4 FOOT PANEL	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP94057	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
E0693	ULTRAVIOLET LIGHT THERAPY SYSTEM PANEL, INCLUDES BULBS/LAMPS, TIMER AND EYE PROTECTION, 6 FOOT PANEL	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP94057	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	

Codes	Code Description	Medical Mutual Commercial	Medical Mutual Commercial Criteria	Medicare Advantage	Medicare Advantage Criteria	Details/Notes
E0694	ULTRAVIOLET MULTIDIRECTIONAL LIGHT THERAPY SYSTEM IN 6 FOOT CABINET, INCLUDES BULBS/LAMPS, TIMER AND EYE PROTECTION	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP94057	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
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 REQUIRED - MEDICAL POLICY	CMP200604	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
E0736	TRANSCUTANEOUS TIBIAL NERVE STIMULATOR	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
E0747	OSTEOGENESIS STIMULATOR, ELECTRICAL, NON\INVASIVE, OTHER THAN SPINAL APPLICATIONS (MAY BE COVERED UNDER SOME NATIONAL CONTRACTS)	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
E0748	OSTEOGENESIS STIMULATOR, ELECTRICAL, NON\INVASIVE, SPINAL APPLICATIONS	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
E0749	OSTEOGENESIS STIMULATOR, ELECTRICAL, SURGICALLY IMPLANTED (MAY BE COVERED UNDER SOME NATIONAL CONTRACTS)	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
E0760	OSTEOGENESIS STIMULATOR, LOW INTENSITY ULTRASOUND, NON\INVASIVE	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
E0764	FUNCTIONAL NEUROMUSCULAR STIMULATOR, TRANSCUTANEOUS STIMULATION OF MUSCLES OF AMBULATION WITH COMPUTER CONTROL, USED FOR WALKING BY SPINAL CORD INJURED, ENTIRE SYSTEM, AFTER COMPLETION OF TRAINING PROGRAM	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP200604	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
E0766	ELECTRICAL STIMULATION DEVICE USED FOR CANCER TREATMENT, INCLUDES ALL ACCESSORIES, ANY TYPE	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201607	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
E0769	ELECTRICAL STIMULATION OR ELECTROMAGNETIC WOUND TREATMENT DEVICE, NOT OTHERWISE CLASSIFIED	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES (See Notes)	MCG A-0242 (CMP202406)	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
E0784	EXT AMBULATORY INFUSION PUMP, INSULIN	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP200117	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
E0787	EXTERNAL AMBULATORY INFUSION PUMP, INSULIN, DOSAGE RATE ADJUSTMENT USING THERAPEUTIC GLUCOSE SENSING	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP200117	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
E0830	AMBULATORY TRACTION DEVICE, ALL TYPES, EACH	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201022	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
E0983	MANUAL WHEELCHAIR ACCESSORY, POWER ADD\ON TO CONVERT MANUAL WHEELCHAIR TO MOTORIZED WHEELCHAIR, JOYSTICK CONTROL	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
E0984	MANUAL WHEELCHAIR ACCESSORY, POWER ADD\ON TO CONVERT MANUAL WHEELCHAIR TO MOTORIZED WHEELCHAIR, TILLER CONTROL	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
E0986	MANUAL WHEELCHAIR ACCESSORY, PUSH ACTIVATED POWER ASSIST, EACH	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
E0988	MANUAL WHEELCHAIR ACCESSORY, LEVER\ACTIVATED, WHEEL DRIVE, PAIR	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
E1002	WHEELCHAIR ACCESSORY, POWER SEATING SYSTEM, TILT ONLY	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
E1004	WHEELCHAIR, POWER SEATING, RECLINE, MECHANICAL SHEAR REDUCTION	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
E1007	WC POWER SEAT SYS COMBO TILT/RECLIN W SHEAR	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
E1008	WHEELCHAIR, SEATING, TILT & RECLINE, POWER SHEAR REDUCTION	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
E1010	WHEELCHAIR ADDITION, POWER LEG ELEVATION SYSTEM	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
E1012	WHEELCHAIR ACCESSORY, ADDITION TO POWER SEAT SYS, POWER ELEVAT LEG REST/PLATFRM	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
E1230	POWER OPERATED VEHICLE, (THREE OR FOUR WHEEL NON\HIGHWAY) SPECIFY BRAND NAME AND MODEL NUMBER (MAY BE COVERED UNDER SOME NATIONAL CONTRACTS)	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
E1231	WHEELCHAIR, PEDIATRIC SIZE, TILT\IN\SPACE, RIGID, ADJUSTABLE, WITH SEATING SYSTEM	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
E1232	WHEELCHAIR, PEDIATRIC SIZE, TILT\IN\SPACE, FOLDING, ADJUSTABLE, WITH SEATING SYSTEM	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
E1233	WHEELCHAIR, PEDIATRIC SIZE, TILT\IN\SPACE, RIGID, ADJUSTABLE, WITHOUT SEATING SYSTEM	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
E1235	WHEELCHAIR, PEDIATRIC SIZE, RIGID, ADJUSTABLE, WITH SEATING SYSTEM	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	

Codes	Code Description	Medical Mutual Commercial	Medical Mutual Commercial Criteria	Medicare Advantage	Medicare Advantage Criteria	Details/Notes
E1239	POWER WHEELCHAIR, PEDIATRIC SIZE, NOT OTHERWISE SPECIFIED	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP202405	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
E1399	DURABLE MEDICAL EQUIPMENT, MISCELLANEOUS(SOME NT'L CONTRACTS COVER)	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP2016-B, MCG A-0998 (CMP202406), CMP201022, CMP201004, CMP202405 Multiple criteria based on item or service.	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
E1810	DYNAMIC ADJUSTABLE KNEE EXTENSION/FLEXION DEVICE, INCLUDES SOFT INTERFACE MATERIAL	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
E1811	STATIC PROGRESSIVE STRETCH KNEE DEVICE, EXTENSION AND/OR FLEXION, WITH OR WITHOUT RANGE OF MOTION ADJUSTMENT, INCLUDES ALL COMPONENTS AND ACCESSORIES	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
E1812	DYNAMIC KNEE, EXTENSION/FLEXION DEVICE WITH ACTIVE RESISTANCE CONTROL	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
E2102	ADJUNCTIVE, NON-IMPLANTED CONTINUOUS GLUCOSE MONITOR OR RECEIVER	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP200117	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
E2103	NON- ADJUNCTIVE, NON-IMPLANTED CONTINUOUS GLUCOSE MONITOR OR RECEIVER	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP200117	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
E2298	COMPLEX REHABILITATIVE POWER WHEELCHAIR ACCESSORY, POWER SEAT ELEVATION SYSTEM, ANY TYPE	PRIOR AUTHORIZATION **NOT** REQUIRED (See notes)	None	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	Prior authorization required for Medicare Advantage only. Refer to the Corporate Medical Policy for commercial plans.
E2300	WHEELCHAIR ACC PWR SEAT ELEVATION SYS ANY TYPE	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED-FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
E2311	POWER WC ACCESS, ELECT CONNECT BETW CHAIR CONTROL & 2 OR > POWER SEAT SYS MOTORS	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
E2312	POWER WHEELCHAIR ACCESSORY, HAND OR CHIN CONTROL INTERFACE, MINI PROPORTIONAL REMOTE JOYSTICK, PROPORTIONAL, INCLUDING FIXED MOUNTING HARDWARE	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
E2313	POWER WHEELCHAIR ACCESSORY, HARNESS FOR UPGRADE TO EXPANDABLE CONTROLLER, INCLUDING ALL FASTENERS, CONNECTORS AND MOUNTING HARDWARE, EACH	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
E2358	POWER WHEELCHAIR ACCESSORY, GROUP 34 NON\SEALED LEAD ACID BATTERY, EACH	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
E2359	POWER WHEELCHAIR ACCESSORY, GROUP 34 SEALED LEAD ACID BATTERY, EACH (EG, GEL CELL, ABSORBED GLASSMAT)	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
E2362	POWER WHEELCHAIR ACCESSORY, GROUP 24 NON\SEALED LEAD ACID BATTERY, EACH	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
E2363	POWER WHEELCHAIR ACCESSORY, GROUP 2R SEALED LEAD ACID BATTERY, EACH (EG., GEL CELL, ABSORBED GLASSMAT)	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
E2368	POWER WHEELCHAIR COMPONENT, MOTOR, REPLACEMENT ONLY	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
E2369	POWER WHEELCHAIR COMPONENT, GEAR BOX, REPLACEMENT ONLY	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
E2370	POWER WHEELCHAIR COMPONENT, MOTOR AND GEAR BOX COMBINATION, REPLACEMENT ONLY	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
E2373	POWER WHEELCHAIR ACCESSORY, HAND OR CHIN CONTROL INTERFACE, COMPACT REMOTE JOYSTICK, PROPORTIONAL, INCLUDING FIXED MOUNTING HARDWARE	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
E2374	POWER WHEELCHAIR ACCESSORY, HAND OR CHIN CONTROL INTERFACE, STANDARD REMOTE JOYSTICK (NOT INCLUDING CONTROLLER), PROPORTIONAL, INCLUDING ALL RELATED ELECTRONICS AND FIXED MOUNTING HARDWARE, REPLACEMENT ONLY	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
E2375	POWER WHEELCHAIR ACCESSORY, NON EXPANDABLE CONTROLLER, INCLUDING ALL RELATED ELECTRONICS AND MOUNTING HARDWARE, REPLACEMENT ONLY	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
E2376	POWER WHEELCHAIR ACCESSORY, EXPANDABLE CONTROLLER, INCLUDING ALL RELATED ELECTRONICS AND MOUNTING HARDWARE, REPLACEMENT ONLY	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
E2377	POWER WHEELCHAIR ACCESSORY, EXPANDABLE CONTROLLER, INCLUDING ALL RELATED ELECTRONICS AND MOUNTING HARDWARE, UPGRADE PROVIDED AT INITIAL ISSUE	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
E2378	POWER WHEELCHAIR COMPONENT, ACTUATOR, REPLACEMENT ONLY	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	

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E2381	POWER WHEELCHAIR ACCESSORY, PNEUMATIC DRIVE WHEEL TIRE, ANY SIZE, REPLACEMENT ONLY, EACH	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
E2382	POWER WHEELCHAIR ACCESSORY, TUBE FOR PNEUMATIC DRIVE WHEEL TIRE, ANY SIZE, REPLACEMENT ONLY, EACH	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
E2383	POWER WHEELCHAIR ACCESSORY, INSERT FOR PNEUMATIC DRIVE WHEEL TIRE (REMOVABLE), ANY TYPE, ANY SIZE, REPLACEMENT ONLY, EACH	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
E2384	POWER WHEELCHAIR ACCESSORY, PNEUMATIC CASTER TIRE, ANY SIZE, REPLACEMENT ONLY, EACH	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
E2385	POWER WHEELCHAIR ACCESSORY, TUBE FOR PNEUMATIC CASTER TIRE, ANY SIZE REPLACEMENT ONLY, EACH	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
E2386	POWER WHEELCHAIR ACCESSORY, FOAM FILLED DRIVE WHEEL TIRE, ANY SIZE, REPLACEMENT ONLY, EACH	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
E2387	POWER WHEELCHAIR ACCESSORY, FOAM FILLED CASTER TIRE, ANY SIZE, REPLACEMENT ONLY, EACH	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
E2388	POWER WHEELCHAIR ACCESSORY, FOAM DRIVE WHEEL TIRE, ANY SIZE, REPLACEMENT ONLY, EACH	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
E2389	POWER WHEELCHAIR ACCESSORY, FOAM CASTER TIRE, ANY SIZE, REPLACEMENT ONLY, EACH	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
E2390	POWER WHEELCHAIR ACCESSORY, SOLID (RUBBER/PLASTIC) DRIVE WHEEL TIRE, ANY SIZE, REPLACEMENT ONLY, EACH	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
E2391	POWER WHEELCHAIR ACCESSORY, SOLID (RUBBER/PLASTIC) CASTER TIRE (REMOVABLE), ANY SIZE, REPLACEMENT ONLY, EACH	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
E2392	POWER WHEELCHAIR ACCESSORY, SOLID (RUBBER/PLASTIC) CASTER TIRE WITH INTEGRATED WHEEL, ANY SIZE, REPLACEMENT ONLY, EACH	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
E2394	POWER WHEELCHAIR ACCESSORY, DRIVE WHEEL EXCLUDES TIRE, ANY SIZE, REPLACEMENT ONLY, EACH	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
E2395	POWER WHEELCHAIR ACCESSORY, CASTER WHEEL EXCLUDES TIRE, ANY SIZE, REPLACEMENT ONLY, EACH	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
E2396	POWER WHEELCHAIR ACCESSORY, CASTER FORK, ANY SIZE, REPLACEMENT ONLY, EACH	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
E2397	POWER WHEELCHAIR ACCESSORY, LITHIUM BASED BATTERY, EACH	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
E2402	NEG PRESSURE WOUND THERAPY ELECTRICAL PUMP	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
E2500	SPEECH GENERATING DEVICE, DIGITIZED SPEECH, USING PRE\RECORDED MESSAGES, LESS THAN OR EQUAL TO 8 MINUTES RECORDING TIME	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
E2502	SPEECH GENERATING DEVICE, DIGITIZED SPEECH, USING PRE\RECORDED MESSAGES, GREATER THAN 8 MINUTES BUT LESS THAN OR EQUAL TO 20 MINUTES RECORDING TIME	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
E2504	SPEECH GENERATING DEVICE, DIGITIZED SPEECH, USING PRE\RECORDED MESSAGES, GREATER THAN 20 MINUTES BUT LESS THAN OR EQUAL TO 40 MINUTES RECORDING TIME	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
E2506	SPEECH GENERATING DEVICE, DIGITIZED SPEECH, USING PRE\RECORDED MESSAGES, GREATER THAN 40 MINUTES RECORDING TIME	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
E2508	SPEECH GENERATING DEVICE, SYNTHESIZED SPEECH, REQUIRING MESSAGE FORMULATION BY SPELLING AND ACCESS BY PHYSICAL CONTACT WITH THE DEVICE	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
E2510	SPEECH GENERATING DEVICE, SYNTHESIZED SPEECH, PERMITTING MULTIPLE METHODS OF MESSAGE FORMULATION AND MULTIPLE METHODS OF DEVICE ACCESS	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
E2511	SPEECH GENERATING SOFTWARE PROGRAM, FOR PERSONAL COMPUTER OR PERSONAL DIGITAL ASSISTANT	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
E2512	ACCESSORY FOR SPEECH GENERATING DEVICE, MOUNTING SYSTEM	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
E2599	ACCESSORY FOR SPEECH GENERATING DEVICE, NOT OTHERWISE CLASSIFIED	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP202405	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
G0130	SINGLE ENERGY X\RAY ABSORPTIOMETRY (SEXA) BONE DENSITY STUDY, ONE OR MORE SITES; APPENDICULAR SKELETON (PERIPHERAL) (E.G., RADIUS, WRIST, HEEL) PROFESSIONAL COMPONENT. TECHNICAL COMPONENT.	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY (See Notes)	CMP94022	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	Prior authorization required if conducted more frequently than every 2 years. See Corporate Medical Policy.
G0260	INJECTION PROCEDURE FOR SACROILIAC JOINT; PROVISION OF ANESTHETIC, STEROID AND/OR OTHER THERAPEUTIC AGENT, WITH OR WITHOUT ARTHROGRAPHY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP202402	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	

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G0295	ELECTROMAGNETIC THERAPY, TO ONE OR MORE AREAS, FOR WOUND CARE OTHER THAN DESCRIBED IN G0329 OR FOR OTHER USES	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES (See Notes)	MCG A-0242 (CMP202406)	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
G0429	DERMAL FILLER INJECTION(S) FOR THE TREATMENT OF FACIAL LIPODYSTROPHY SYNDROME (LDS) (E.G., AS A RESULT OF HIGHLY ACTIVE ANTIRETROVIRAL THERAPY)	PRIOR AUTHORIZATION **NOT** REQUIRED (See notes)	None	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
G0455	PREPARATION WITH INSTILLATION OF FECAL MICROBIOTA BY ANY METHOD, INCLUDING ASSESSMENT OF DONOR SPECIMEN	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP202301	PRIOR AUTHORIZATION NOT REQUIRED		
H2019	THERAPEUTIC BEHAVIORAL SERVICES, PER 15 MINUTES	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION NOT REQUIRED		
J0585	INJECTION, ONABOTULINUMTOXINA, 1 UNIT	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CDP201516	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
J0895	INJECTION, DEFEROXAMINE MESYLATE, 500 MG	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP 200237 Chelation Therapy	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
J2787	RIBOFLAVIN 5'-PHOSPHATE, OPHTHALMIC SOLUTION, UP TO 3 ML	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION NOT REQUIRED		
J7330	AUTOLOGOUS CULTURED CHONDROCYTES, IMPLANT	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP200613	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
K0005	ULTRALIGHTWEIGHT WHEELCHAIR	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
K0010	STANDARD\WEIGHT FRAME MOTORIZED/POWER WHEELCHAIR	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
K0011	STANDARD\WEIGHT FRAME MOTORIZED/POWER WHEELCHAIR WITH PROGRAMMABLE CONTROL PARAMETERS FOR SPEED ADJUSTMENT, TREMOR DAMPENING, ACCELERATION CONTROL AND BRAKING	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
K0012	LIGHTWEIGHT PORTABLE MOTORIZED/POWER WHEELCHAIR	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
K0013	CUSTOM MOTORIZED/POWER WHEELCHAIR BASE	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
K0014	OTHER MOTORIZED/POWER WHEELCHAIR BASE	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
K0108	WHEELCHAIR COMPONENT OR ACCESSORY, NOT OTHERWISE SPECIFIED	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP202405	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
K0800	POWER OPERATED VEHICLE, GROUP 1 STANDARD, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 LBS	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
K0801	POWER OPERATED VEHICLE, GROUP 1 HEAVY DUTY, PATIENT WEIGHT CAPACITY 301 450 POUNDS	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
K0802	POWER OPERATED VEHICLE, GROUP 1 VERY HEAVY DUTY, PATIENT WEIGHT CAPACITY 451 600 POUNDS	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
K0806	POWER OPERATED VEHICLE, GROUP 2 STANDARD, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
K0807	POWER OPERATED VEHICLE, GROUP 2 HEAVY DUTY, PATIENT WEIGHT CAPACITY 301 450 POUNDS	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
K0808	POWER OPERATED VEHICLE, GROUP 2 VERY HEAVY DUTY, PATIENT WEIGHT CAPACITY 451 TO 600 POUNDS	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
K0812	POWER OPERATED VEHICLE, NOT OTHERWISE CLASSIFIED	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP202405	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
K0813	POWER WHEELCHAIR, GROUP 1 STANDARD, PORTABLE, SLING/SOLID SEAT AND BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
K0814	POWER WHEELCHAIR, GROUP 1 STANDARD, PORTABLE, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
K0815	POWER WHEELCHAIR, GROUP 1 STANDARD, SLING/SOLID SEAT AND BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
K0816	POWER WHEELCHAIR, GROUP 1 STANDARD, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
K0820	POWER WHEELCHAIR, GROUP 2 STANDARD, PORTABLE, SLING/SOLID SEAT/BACK PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
K0821	POWER WHEELCHAIR, GROUP 2 STANDARD, PORTABLE, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
K0822	POWER WHEELCHAIR, GROUP 2 STANDARD, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	

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K0823	POWER WHEELCHAIR, GROUP 2 STANDARD, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
K0824	POWER WHEELCHAIR, GROUP 2 HEAVY DUTY, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
K0825	POWER WHEELCHAIR, GROUP 2 HEAVY DUTY, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
K0826	POWER WHEELCHAIR, GROUP 2 VERY HEAVY DUTY, SLING/SOLID SEAT/BACK PATIENT WEIGHT CAPACITY 451 TO 650 POUNDS	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
K0827	POWER WHEELCHAIR, GROUP 2 VERY HEAVY DUTY, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY 451 TO 600 POUNDS	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
K0828	POWER WHEELCHAIR, GROUP 2 EXTRA HEAVY DUTY, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 601 POUNDS OR MORE.	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
K0829	POWER WHEELCHAIR, GROUP 2 EXTRA HEAVY DUTY, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY 601 POUNDS OR MORE	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
K0830	POWER WHEELCHAIR, GROUP 2 STANDARD, SEAT ELEVATOR, SLING/SOLID SEAT/ BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS.	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
K0831	POWER WHEELCHAIR, GROUP 2 STANDARD, SEAT ELEVATOR, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS.	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
K0835	POWER WHEELCHAIR, GROUP 2 STANDARD, SINGLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
K0836	POWER WHEELCHAIR, GROUP 2 STANDARD, SINGLE POWER OPTION, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
K0837	POWER WHEELCHAIR, GROUP 2 HEAVY DUTY, SINGLE POWER OPTION, SLING/ SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
K0838	POWER WHEELCHAIR, GROUP 2 HEAVY DUTY, SINGLE POWER OPTION, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
K0839	POWER WHEELCHAIR, GROUP 2 VERY HEAVY DUTY, SINGLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 451 TO 600 POUNDS	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
K0840	POWER WHEELCHAIR, GROUP 2 EXTRA HEAVY DUTY, SINGLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 601 POUNDS OR MORE	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
K0841	POWER WHEELCHAIR, GROUP 2 STANDARD, MULTIPLE POWER OPTION, SLING/ SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
K0842	POWER WHEELCHAIR, GROUP 2 STANDARD, MULTIPLE POWER OPTION, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
K0843	POWER WHEELCHAIR, GROUP 2 HEAVY DUTY, MULTIPLE POWER OPTION, SLING/ SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
K0848	POWER WHEELCHAIR, GROUP 3 STANDARD, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
K0849	POWER WHEELCHAIR, GROUP 3 STANDARD, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
K0850	POWER WHEELCHAIR, GROUP 3 HEAVY DUTY, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
K0851	POWER WHEELCHAIR, GROUP 3 HEAVY DUTY, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
K0852	POWER WHEELCHAIR, GROUP 3 VERY HEAVY DUTY, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 451 TO 600 POUNDS.	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
K0853	POWER WHEELCHAIR, GROUP 3 VERY HEAVY DUTY, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY 451 TO 600 POUNDS	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
K0854	POWER WHEELCHAIR, GROUP 3 EXTRA HEAVY DUTY, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 601 POUNDS OR MORE	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
K0855	POWER WHEELCHAIR, GROUP 3 EXTRA HEAVY DUTY, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY 601 POUNDS OR MORE	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
K0856	POWER WHEELCHAIR, GROUP 3 STANDARD, SINGLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
K0857	POWER WHEELCHAIR, GROUP 3 STANDARD, SINGLE POWER OPTION, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
K0858	POWER WHEELCHAIR, GROUP 3 HEAVY DUTY, SINGLE POWER OPTION, SLING/ SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	

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K0859	POWER WHEELCHAIR, GROUP 3 HEAVY DUTY, SINGLE POWER OPTION, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
K0860	POWER WHEELCHAIR, GROUP 3 VERY HEAVY DUTY, SINGLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 451 TO 600 POUNDS	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
K0861	POWER WHEELCHAIR, GROUP 3 STANDARD, MULTIPLE POWER OPTION, SLING/ SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
K0862	POWER WHEELCHAIR, GROUP 3 HEAVY DUTY, MULTIPLE POWER OPTION, SLING/ SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
K0863	POWER WHEELCHAIR, GROUP 3 VERY HEAVY DUTY, MULTIPLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 451 TO 600 POUNDS	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
K0864	POWER WHEELCHAIR, GROUP 3 EXTRA HEAVY DUTY, MULTIPLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 601 POUNDS OR MORE	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
K0868	POWER WHEELCHAIR, GROUP 4 STANDARD, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
K0869	POWER WHEELCHAIR, GROUP 4 STANDARD, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
K0870	POWER WHEELCHAIR, GROUP 4 HEAVY DUTY, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
K0871	POWER WHEELCHAIR, GROUP 4 VERY HEAVY DUTY, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 451 TO 600 POUNDS	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
K0877	POWER WHEELCHAIR, GROUP 4 STANDARD, SINGLE POWER OPTION, SLING/ SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
K0878	POWER WHEELCHAIR, GRP 4 STANDARD, SINGLE POWER OPTION, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
K0879	POWER WHEELCHAIR, GROUP 4 HEAVY DUTY, SINGLE POWER OPTION, SLING/ SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
K0880	POWER WHEELCHAIR, GROUP 4 VERY HEAVY DUTY, SINGLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 451 TO 600 POUNDS	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
K0884	POWER WHEELCHAIR, GROUP 4 STANDARD, MULTIPLE POWER OPTION, SLING/ SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
K0885	POWER WHEELCHAIR, GROUP 4 STANDARD, MULTIPLE POWER OPTION, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
K0886	POWER WHEELCHAIR, GROUP 4 HEAVY DUTY, MULTIPLE POWER OPTION, SLING/ SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
K0890	POWER WHEELCHAIR, GROUP 5 PEDIATRIC, SINGLE POWER OPTION, SLING/ SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 125 POUNDS	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
K0891	POWER WHEELCHAIR, GROUP 5 PEDIATRIC, MULTIPLE POWER OPTION, SLING/ SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 125 POUNDS	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
K0898	POWER WHEELCHAIR, NOT OTHERWISE CLASSIFIED	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP202405	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
K0899	POWER MOBILITY DEVICE, NOT CODED BY DME PDAC OR DOES NOT MEET CRITERIA	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP202405	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
L1320	THORACIC, PECTUS CARINATUM ORTHOSIS, STERNAL COMPRESSION, RIGID CIRCUMFERENTIAL FRAME WITH ANTERIOR AND POSTERIOR RIGID PADS, CUSTOM FABRICATED	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP200905	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP	
L1844	KNEE ORTHOSIS, SINGLE UPRIGHT, THIGH AND CALF, WITH ADJUSTABLE FLEXION AND EXTENSION JOINT (UNICENTRIC OR POLYCENTRIC), MEDIAL LATERAL AND ROTATION CONTROL, WITH OR WITHOUT VARUS/VALGUS ADJUSTMENT, CUSTOM FABRICATED	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
L1846	KNEE ORTHOSIS, DOUBLE UPRIGHT, THIGH AND CALF, WITH ADJUSTABLE FLEXION AND EXTENSION JOINT (UNICENTRIC OR POLYCENTRIC), MEDIAL LATERAL AND ROTATION CONTROL, WITH OR WITHOUT VARUS/VALGUS ADJUSTMENT, CUSTOM FABRICATED	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
L1860	KNEE ORTHOSIS, MODIFICATION OF SUPRACONDYLAR PROSTHETIC SOCKET, CUSTOM FABRICATED (SK) (SOME NATIONAL CONTRACTS MAY COVER)	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	

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L3999	UPPER LIMB ORTHOSIS, NOT OTHERWISE SPECIFIED	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP2016-B	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP	
L5856	ADDITION TO LOWER EXTREMITY PROSTHESIS, ENDOSKELETAL KNEE\SHIN SYSTEM, MICROPROCESSOR CONTROL FEATURE, SWING AND STANCE PHASE, INCLUDES ELECTRONIC SENSOR(S), ANY TYPE	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
L5973	ENDOSKELETAL ANKLE\FOOT SYSTEM, MICROPROCESSOR CONTROLLED FEATURE, DORSIFLEXION AND/OR PLANTAR FLEXION CONTROL, INCLUDES POWER SOURCE	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
L5999	LOWER EXTREMITY PROSTHESIS, NOT OTHERWISE SPECIFIED	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP202405	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
L6700	UPPER EXTREMITY ADDITION, EXTERNAL POWERED FEATURE, MYOELECTRONIC CONTROL MODULE, ADDITIONAL EMG INPUTS, PATTERN-RECOGNITION DECODING INTENT MOVEMENT	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
L6880	ELECTRIC HAND, SWITCH OR MYOELECTRIC CONTROLLED, INDEPENDENTLY ARTICULATING DIGITS, ANY GRASP PATTERN OR COMBINATION OF GRASP PATTERNS, INCLUDES MOTOR(S)	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
L6925	WRIST DISARTICULATION, EXT. POWER, MYOELECTRONIC CONTROL	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
L6955	ABOVE ELBOW, EXTERNAL POWER, MYOELECTRONIC CONTROL	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
L7499	UPPER EXTREMITY PROSTHESIS, NOT OTHERWISE SPECIFIED	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP202405, CMP2016-B	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP	
L8420	PROSTHETIC SOCK, MULT PLY; BELOW KNEE, EA	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
L8600	IMPLANTABLE BREAST PROSTHESIS, SILICONE OR EQUAL	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY (See Notes)	CMP94002	PRIOR AUTHORIZATION REQUIRED-MEDICAL POLICY-SEE NOTES	CMP	Prior authorization not required for personal history of breast cancer.
L8603	INJECTABLE BULKING AGENT, COLLAGEN IMPLANT, URINARY TRACT, 2.5 ML SYRINGE, INCLUDES SHIPPING AND NECESSARY SUPPLIES	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
L8610	OCULAR IMPLANT	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP200504	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP	
L8612	AQUEOUS SHUNT	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201721	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP	
L8614	COCHLEAR DEVICE, INCLUDES ALL INTERNAL AND EXTERNAL COMPONENTS	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP202020	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
L8615	HEADSET/HEADPIECE FOR USE WITH COCHLEAR IMPLANT DEVICE, REPLACEMENT	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP202020	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
L8616	MICROPHONE FOR USE WITH COCHLEAR IMPLANT DEVICE, REPLACEMENT	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP202020	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
L8617	TRANSMITTING COIL FOR USE WITH COCHLEAR IMPLANT DEVICE, REPLACEMENT	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP202020	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
L8618	TRANSMITTER CABLE FOR USE WITH COCHLEAR IMPLANT DEVICE OR AUDITORY OSSEOINTEGRATED DEVICE, REPLACEMENT	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP202020	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
L8619	COCHLEAR IMPLANT, EXTERNAL SPEECH PROCESSOR AND CONTROLLER, INTEGRATED SYSTEM, REPLACEMENT	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP202020	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
L8621	ZINC AIR BATTERY FOR USE WITH COCHLEAR IMPLANT DEVICE AND AUDITORY OSSEOINTEGRATED SOUND PROCESSORS, REPLACEMENT, EACH	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP202020	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES (See Notes)	MCG	*Only requires review if age is less than 1 year
L8622	ALKALINE BATTERY FOR USE WITH COCHLEAR IMPLANT DEVICE, ANY SIZE, REPLACEMENT, EACH	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP202020	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES (See Notes)	MCG	*Only requires review if age is less than 1 year
L8623	LITHIUM ION BATTERY FOR USE WITH COCHLEAR IMPLANT DEVICE SPEECH PROCESSOR, OTHER THAN EAR LEVEL, REPLACEMENT, EACH	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP202020	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES (See Notes)	MCG	*Only requires review if age is less than 1 year
L8624	LITHIUM ION BATTERY FOR USE WITH COCHLEAR IMPLANT OR AUDITORY OSSEOINTEGRATED DEVICE SPEECH PROCESSOR, EAR LEVEL, REPLACEMENT, EACH	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP202020	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES (See Notes)	MCG	*Only requires review if age is less than 1 year
L8625	EXTERNAL RECHARGING SYSTEM FOR BATTERY FOR USE WITH COCHLEAR IMPLANT OR AUDITORY OSSEOINTEGRATED DEVICE, REPLACEMENT ONLY, EACH	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP202020, MCG A-0564	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
L8627	COCHLEAR IMPLANT, EXTERNAL SPEECH PROCESSOR, COMPONENT, REPLACEMENT	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP202020	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
L8628	COCHLEAR IMPLANT, EXTERNAL CONTROLLER COMPONENT, REPLACEMENT	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP202020	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
L8629	TRANSMITTING COIL AND CABLE, INTEGRATED, FOR USE WITH COCHLEAR IMPLANT DEVICE, REPLACEMENT	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP202020	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	

Codes	Code Description	Medical Mutual Commercial	Medical Mutual Commercial Criteria	Medicare Advantage	Medicare Advantage Criteria	Details/Notes
L8678	ELECTRICAL STIMULATOR SUPPLIES (EXTERNAL) FOR USE WITH IMPLANTABLE NEUROSTIMULATOR, PER MONTH	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP200602, CMP201004	PRIOR AUTHORIZATION REQUIRED-FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
L8679	IMPLANTABLE NEUROSTIMULATOR, PULSE GENERATOR, ANY TYPE	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP200602, MCG B-821-T (CMP202406)	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
L8681	PATIENT PROGRAMMER (EXTERNAL) FOR USE WITH IMPLANTABLE PROGRAMMABLE NEUROSTIMULATOR PULSE GENERATOR, REPLACEMENT ONLY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201004	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
L8690	AUDITORY OSSEOINTEGRATED DEVICE, INCLUDES ALL INTERNAL AND EXTERNAL COMPONENTS	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
L8691	AUDITORY OSSEOINTEGRATED DEVICE, EXTERNAL SOUND PROCESSOR, EXCLUDES TRANSDUCER/ACTUATOR, REPLACEMENT ONLY, EACH	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
L8692	AUDITORY OSSEOINTEGRATED DEVICE, EXTERNAL SOUND PROCESSOR, USED WITHOUT OSSEOINTEGRATION, BODY WORN, INCLUDES HEADBAND OR OTHER MEANS OF EXTERNAL ATTACHMENT	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
L8693	AUDITORY OSSEOINTEGRATED DEVICE ABUTMENT, ANY LENGTH, REPLACEMENT ONLY	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
L8694	Auditory osseointegrated device, transducer/actuator, replacement only, each	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
L8699	PROSTHETIC IMPLANT, NOS	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201609, CMP202405	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
P9020	PLATELET RICH PLASMA, EACH UNIT	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES (See Notes)	MCG A-0630 (CMP202407)	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
Q0507	MISCELLANEOUS SUPPLY OR ACCESORY FOR USE WITH AN EXTERNAL VENTRICULAR ASSIST DEVICE	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP202405	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
Q0508	MISCELLANEOUS SUPPLY OR ACCESSORY FOR USE WITH AN IMPLANTED VENTRICULAR ASSIST DEVICE	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP202405	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
Q0509	MISCELLANEOUS SUPPLY OR ACCESSORY FOR USE ANY IMPLANTED VENTRICULAR ASSIST DEVICE FOR WHICH PAYMENT WAS NOT MADE UNDER MEDICARE PART A	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP202405	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
Q4100	SKIN SUBSTITUTE, NOT OTHERWISE SPECIFIED	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP200233, CMP202405	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
Q4104	INTEGRA BILAYER MATRIX WOUND DRESSING (BMWD), PER SQUARE CENTIMETER	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP200233	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
Q4105	INTEGRA DERMAL REGENERATION TEMPLATE (DRT) OR INTEGRA OMNIGRAFT DERMAL REGENERATION MATRIX, PER SQUARE CENTIMETER	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP200233	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
Q4116	ALLODERM, PER SQUARE CENTIMETER	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP200233	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
Q4122	DERMACELL, DERMACELL AWM OR DERMACELL AWM POROUS, PER SQUARE CENTIMETER	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP200233	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
Q4124	OASIS ULTRA TRI-LAYER WOUND MATRIX, PER SQUARE CENTIMETER	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP200233	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
Q4186	EPIFIX, PER SQUARE CENTIMETER	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4187	EPICORD, PER SQUARE CENTIMETER	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4213	ASCENT, 0.5 MG	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP 200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4219	SURGIGRAFT-DUAL, PER SQ CM	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP 200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4220	BELLACELL HD OR SUREDERM, PER SQ CM	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP 200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4221	AMNIO WRAP2, PER SQ CM	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP 200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4227	AMNIOCORE, PER SQ CM	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP 200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4229	COGENEX AMNIOTIC MEMBRANE, PER SQ CM	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP 200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4230	COGENEX FLOWABLE AMNION, PER 0.5 CC	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP 200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4231	CORPLEX P PER CC	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP 200233	PRIOR AUTHORIZATION NOT REQUIRED		

Codes	Code Description	Medical Mutual Commercial	Medical Mutual Commercial Criteria	Medicare Advantage	Medicare Advantage Criteria	Details/Notes
Q4232	CORPLEX, PER SQ CM	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP 200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4233	SURFACTOR OR NUDYN, PER 0.5 CC	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP 200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4238	DERM-MAXX, PER SQ CM	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP 200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4241	POLYCYTE, FOR TOPICAL USE ONLY, PER 0.5 CC	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP 200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4242	AMNIOCYTE PLUS, PER 0.5 CC	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP 200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4246	CORETEXT OR PROTEXT, PER CC	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP 200233	PRIOR AUTHORIZATION NOT REQUIRED		
S1034	ARTIFICIAL PANCREAS DEVICE SYSTEM (E.G., LOW GLUCOSE SUSPEND (LGS) FEATURE) INCLUDING CONTINUOUS GLUCOSE MONITOR, BLOOD GLUCOSE DEVICE, INSULIN PUMP AND COMPUTER ALGORITHM THAT COMMUNICATES WITH ALL OF THE DEVICES	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP200117	NON-COVERED		Per CMS this code is identified as a non-covered code for Medicare Advantage plans.
S1040	CRANIAL REMOLDING ORTHOSIS ,PEDIATRIC, RIGID, WITH SOFT INTERFACE MATERIAL, CUSTOM FABRICATED, INCLUDES FITTING AND ADJUSTMENT(S) MAY NOT BE COVERED UNDER SOME NATIONAL ACCOUNTS.	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	NON-COVERED		Per CMS this code is identified as a non-covered code for Medicare Advantage plans.
S2066	BREAST RECONSTRUCTION WITH GLUTEALARTERY PERFORATOR (GAP) FLAP, INCLUDING HARVESTING OF THE FLAP, MICROVASCULAR TRANSFER, CLOSURE OF DONOR SITE AND SHAPING THE FLAP INTO A BREAST, UNILATERAL	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP94002	NON-COVERED		Per CMS this code is identified as a non-covered code for Medicare Advantage plans.
S2067	BREAST RECONSTRUCTION OF A SINGLE BREAST WITH 'STACKED' DEEP INFERIOR EPIGASTRIC PERFORATOR (DIEP) FLAP(S) AND/OR GLUTEAL ARTERY PERFORATOR (GAP) FLAP(S), INCLUDING HARVESTING OF THE FLAP(S), MICROVASCULAR TRANSFER, CLOSURE OF DONOR SITE(S) AND SHAPING THE FLAP INTO A BREAST, UNILATERAL	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP94002	NON-COVERED		Per CMS this code is identified as a non-covered code for Medicare Advantage plans.
S2068	BREAST RECONSTRUCTION WITH DEEP INFERIOR EPIGASTRIC PERFORATOR(DIEP) FLAP, OR SUPERFICIAL INFERIOR EPIGASTRIC ARTERY (SIEA) FLAP, INCLUDING HARVESTING OF THE FLAP, MICROVASCULAR TRANSFER, CLOSURE OF DONOR SITE AND SHAPING THE FLAP INTO A BREAST, UNILATERAL	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP94002	NON-COVERED		Per CMS this code is identified as a non-covered code for Medicare Advantage plans.
S2083	ADJUSTMENT OF GASTRIC BAND DIAMETER VIA SUBCUTANEOUS PORT BY INJECTION OR ASPIRATION OF SALINE	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP94030	NON-COVERED		
S2102	ISLET CELL TISSUE TRANSPLANT FROM PANCREAS; ALLOGENEIC	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP201102	NON-COVERED		
S2112	ISLET CELL TISSUE TRANSPLANT FROM PANCREAS; ALLOGENEIC	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP200613	NON-COVERED		
S2230	IMPLANTATION OF MAGNETIC COMPONENET OF SEMI\IMPLANTABLE HEARING DEVICE ON OSSICLES IN MIDDLE EAR	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	NON-COVERED		Per CMS this code is identified as a non-covered code for Medicare Advantage plans.
S2235	IMPLANTATION OF AUDITORY BRAIN STEM IMPLANT	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	NON-COVERED		Per CMS this code is identified as a non-covered code for Medicare Advantage plans.
S2402	REPAIR, CONGENITAL CYSTIC ADENOMATOID MALFORMATION IN THE FETUS, PROCEDURE PERFORMED IN UTERO	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP200407	NON-COVERED		Per CMS this code is identified as a non-covered code for Medicare Advantage plans.
S3800	GENETIC TESTING FOR AMYOTROPHIC LATERAL SCLEROSIS (ALS)	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY (See Notes)	CMP201303	NON-COVERED		
S3841	GENETIC TESTING FOR RETINOBLASTOMA	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY (See Notes)	CMP201303	NON-COVERED		
S3842	GENETIC TESTING FOR VON HIPPEL-LINDAU DISEASE	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY (See Notes)	CMP201303	NON-COVERED		
S3850	GENETIC TESTING FOR SICKLE CELL ANEMIA	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY (See Notes)	CMP201303	NON-COVERED		
S3853	GENETIC TESTING FOR MYOTONIC MUSCULAR DYSTROPHY	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY (See Notes)	CMP201303	NON-COVERED		
S3861	GENETIC TESTING, SODIUM CHANNEL, VOLTAGE GATED, TYPE V, ALPHA SUBUNIT (SCN5A) AND VARIANTS FOR SUSPECTED BRUGADA SYNDROME	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	NON-COVERED		
S3865	COMPREHENSIVE GENE SEQUENCE ANALYSIS FOR HYPERTROPHIC CARDIOMYOPATHY	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	NON-COVERED		
S3870	COMPARATIVE GENOMIC HYBRIDIZATION (CGH) MICROARRAY TESTING FOR DEVELOPMENTAL DELAY, AUTISM SPECTRUM DISORDER AND/OR INTELLECTUAL DISABILITY	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	NON-COVERED		
S8948	APPLICATION OF A MODALITY (REQUIRING CONSTANT PROVIDER ATTENDANCE) TO ONE OR MORE AREAS; LOW-LEVEL LASER; EACH 15 MINUTES	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP202206	NON-COVERED		

Codes	Code Description	Medical Mutual Commercial	Medical Mutual Commercial Criteria	Medicare Advantage	Medicare Advantage Criteria	Details/Notes
S9123	NURSING CARE, IN THE HOME; BY REGISTERED NURSE, PER HOUR (USE FOR GENERAL NURSING CARE ONLY, NOT TO BE USED WHEN CPT CODES 99500\99602 CAN BE USED)	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	NON-COVERED		
S9124	NURSING CARE, IN THE HOME; BY LICENSED PRACTICAL NURSE, PER HOUR	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	NON-COVERED		
S9960	AMBULANCE SERVICE, CONVENTIONAL AIR SERVICE, NONEMERGENCY TRANSPORT, ONE WAY (FIXED WING)	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP200231, CMP202405	NON-COVERED		

Cohere Delegated Codes

Cohere Health Login: https://login.coherehealth.com Fax: (570) 684-4168 Phone: (855) 482-3649

Cohere Review Criteria Guidelines https://payerinfo.zendesk.com/hc/en-us/articles/20944358235159-Cohere-Guidelines-All-Specialties

Codes	Code Description	Medical Mutual Commercial	Medical Mutual Commercial Criteria	Medicare Advantage	Medicare Advantage Criteria	Details/Notes
21685	Hyoid myotomy and suspension	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
33206	Insertion of new or replacement of permanent pacemaker with transvenous electrode(s); atrial	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
33207	Insertion of new or replacement of permanent pacemaker with transvenous electrode(s); ventricular	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
33208	Insertion of new or replacement of permanent pacemaker with transvenous electrode(s); atrial and ventricular	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
33210	Insertion or replacement of temporary transvenous single chamber cardiac electrode or pacemaker catheter (separate procedure)	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
33211	Insertion or replacement of temporary transvenous dual chamber pacing electrodes (separate procedure)	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
33212	Insertion of pacemaker pulse generator only; with existing single lead	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
33213	Insertion of pacemaker pulse generator only; with existing dual leads	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
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...	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
33216	Insertion of a single transvenous electrode, permanent pacemaker or implantable defibrillator	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
33217	Insertion of 2 transvenous electrodes, permanent pacemaker or implantable defibrillator	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
33221	Insertion of pacemaker pulse generator only; with existing multiple leads	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
33224	Insertion of pacing electrode, cardiac venous system, for left ventricular pacing, with attachment to previously placed pacemaker or implantable defibrillator pulse generator (including revision o...	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
33230	Insertion of implantable defibrillator pulse generator only; with existing dual leads	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
33231	Insertion of implantable defibrillator pulse generator only; with existing multiple leads	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
33240	Insertion of implantable defibrillator pulse generator only; with existing single lead	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
33249	Insertion or replacement of permanent implantable defibrillator system, with transvenous lead(s), single or dual chamber	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
33270	Insertion or replacement of permanent subcutaneous implantable defibrillator system, with subcutaneous electrode, including defibrillation threshold evaluation, induction of arrhythmia, evaluation...	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
33271	Insertion of subcutaneous implantable defibrillator electrode	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
33273	Repositioning of previously implanted subcutaneous implantable defibrillator electrode	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
33277	Insertion of phrenic nerve stimulator transvenous sensing lead (List separately in addition to code for primary procedure)	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	

Codes	Code Description	Medical Mutual Commercial	Medical Mutual Commercial Criteria	Medicare Advantage	Medicare Advantage Criteria	Details/Notes
33279	Removal of phrenic nerve stimulator, including vessel catheterization, all imaging guidance, and interrogation and programming, when performed; transvenous stimulation or sensing lead(s) only	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
33280	Removal of phrenic nerve stimulator, including vessel catheterization, all imaging guidance, and interrogation and programming, when performed; pulse generator only	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
33281	Repositioning of phrenic nerve stimulator transvenous lead(s)	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
33285	Insertion, subcutaneous cardiac rhythm monitor, including programming	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
33287	Removal and replacement of phrenic nerve stimulator, including vessel catheterization, all imaging guidance, and interrogation and programming, when performed; pulse generator	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
33288	Removal and replacement of phrenic nerve stimulator, including vessel catheterization, all imaging guidance, and interrogation and programming, when performed; transvenous stimulation or sensing l...	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
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 REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
33340	Percutaneous transcatheter closure of the left atrial appendage with endocardial implant, including fluoroscopy, transseptal puncture, catheter placement(s), left atrial angiography, left atrial a...	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
33361	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; percutaneous femoral artery approach	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
33362	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; open femoral artery approach	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
33363	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; open axillary artery approach	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
33364	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; open iliac artery approach	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
33365	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; transaortic approach (eg, median sternotomy, mediastinotomy)	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
33366	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; transapical exposure (eg, left thoracotomy)	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
33418	Transcatheter mitral valve repair, percutaneous approach, including transseptal puncture when performed; initial prosthesis	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
33875	Descending thoracic aorta graft, with or without bypass	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
33877	Repair of thoracoabdominal aortic aneurysm with graft, with or without cardiopulmonary bypass	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
33880	Endovascular repair of descending thoracic aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption); involving coverage of left subclavian ...	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
33881	Endovascular repair of descending thoracic aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption); not involving coverage of left subclav...	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
33883	Placement of proximal extension prosthesis for endovascular repair of descending thoracic aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disr...	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
33886	Placement of distal extension prosthesis(s) delayed after endovascular repair of descending thoracic aorta	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
34701	Endovascular repair of infrarenal aorta by deployment of an aorto-aortic tube endograft including pre-procedure sizing and device selection, all nonselective catheterization(s), all associated rad...	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
34702	Endovascular repair of infrarenal aorta by deployment of an aorto-aortic tube endograft including pre-procedure sizing and device selection, all nonselective catheterization(s), all associated rad...	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	

Codes	Code Description	Medical Mutual Commercial	Medical Mutual Commercial Criteria	Medicare Advantage	Medicare Advantage Criteria	Details/Notes
34703	Endovascular repair of infrarenal aorta and/or iliac artery(ies) by deployment of an aorto-uni-iliac endograft including pre-procedure sizing and device selection, all nonselective catheterization...	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
34704	Endovascular repair of infrarenal aorta and/or iliac artery(ies) by deployment of an aorto-uni-iliac endograft including pre-procedure sizing and device selection, all nonselective catheterization...	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
34705	Endovascular repair of infrarenal aorta and/or iliac artery(ies) by deployment of an aorto-bi-iliac endograft including pre-procedure sizing and device selection, all nonselective catheterization(...	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
34706	Endovascular repair of infrarenal aorta and/or iliac artery(ies) by deployment of an aorto-bi-iliac endograft including pre-procedure sizing and device selection, all nonselective catheterization(...	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
34830	Open repair of infrarenal aortic aneurysm or dissection, plus repair of associated arterial trauma, following unsuccessful endovascular repair; tube prosthesis	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
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 REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
34832	Open repair of infrarenal aortic aneurysm or dissection, plus repair of associated arterial trauma, following unsuccessful endovascular repair; aorto-bifemoral prosthesis	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
34841	Endovascular repair of visceral aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption) by deployment of a fenestrated visceral aortic end...	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
34842	Endovascular repair of visceral aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption) by deployment of a fenestrated visceral aortic end...	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
34843	Endovascular repair of visceral aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption) by deployment of a fenestrated visceral aortic end...	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
34844	Endovascular repair of visceral aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption) by deployment of a fenestrated visceral aortic end...	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
34845	Endovascular repair of visceral aorta and infrarenal abdominal aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption) with a fenestrated ...	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
34846	Endovascular repair of visceral aorta and infrarenal abdominal aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption) with a fenestrated ...	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
34847	Endovascular repair of visceral aorta and infrarenal abdominal aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption) with a fenestrated ...	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
34848	Endovascular repair of visceral aorta and infrarenal abdominal aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption) with a fenestrated ...	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
35301	Thromboendarterectomy, including patch graft, if performed; carotid, vertebral, subclavian, by neck incision	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
36245	Selective catheter placement, arterial system; each first order abdominal, pelvic, or lower extremity artery branch, within a vascular family	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
36246	Selective catheter placement, arterial system; initial second order abdominal, pelvic, or lower extremity artery branch, within a vascular family	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
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 REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
37215	Transcatheter placement of intravascular stent(s), cervical carotid artery, open or percutaneous, including angioplasty, when performed, and radiological supervision and interpretation; with dista...	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
37216	Transcatheter placement of intravascular stent(s), cervical carotid artery, open or percutaneous, including angioplasty, when performed, and radiological supervision and interpretation; without di...	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	

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37217	Transcatheter placement of intravascular stent(s), intrathoracic common carotid artery or innominate artery by retrograde treatment, open ipsilateral cervical carotid artery exposure, including an...	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
37218	Transcatheter placement of intravascular stent(s), intrathoracic common carotid artery or innominate artery, open or percutaneous antegrade approach, including angioplasty, when performed, and rad...	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
37220	Revascularization, endovascular, open or percutaneous, iliac artery, unilateral, initial vessel; with transluminal angioplasty	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
37221	Revascularization, endovascular, open or percutaneous, iliac artery, unilateral, initial vessel; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
37224	Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with transluminal angioplasty	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
37225	Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with atherectomy, includes angioplasty within the same vessel, when performed	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
37226	Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
37227	Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with transluminal stent placement(s) and atherectomy, includes angioplasty within the same vessel, ...	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
37228	Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with transluminal angioplasty	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
37229	Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with atherectomy, includes angioplasty within the same vessel, when performed	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
37230	Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with transluminal stent placement(s), includes angioplasty within the same vessel, when ...	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
37231	Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with transluminal stent placement(s) and atherectomy, includes angioplasty within the sa...	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
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 co...	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
37238	Transcatheter placement of an intravascular stent(s), open or percutaneous, including radiological supervision and interpretation and including angioplasty within the same vessel, when performed; ...	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
41512	Tongue base suspension, permanent suture technique	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
41530	Submucosal ablation of the tongue base, radiofrequency, 1 or more sites, per session	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
42140	Uvulectomy, excision of uvula	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
42145	Palatopharyngoplasty (eg, uvulopalatopharyngoplasty, uvulopharyngoplasty)	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
42950	Pharyngoplasty (plastic or reconstructive operation on pharynx)	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
43235	Esophagogastroduodenoscopy, flexible, transoral; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
43237	Esophagogastroduodenoscopy, flexible, transoral; with endoscopic ultrasound examination limited to the esophagus, stomach or duodenum, and adjacent structures	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
43238	Esophagogastroduodenoscopy, flexible, transoral; with transendoscopic ultrasound-guided intramural or transmural fine needle aspiration/biopsy(s), (includes endoscopic ultrasound examination limit...	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
43239	Esophagogastroduodenoscopy, flexible, transoral; with biopsy, single or multiple	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	

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43242	Esophagogastroduodenoscopy, flexible, transoral; with transendoscopic ultrasound-guided intramural or transmural fine needle aspiration/biopsy(s) (includes endoscopic ultrasound examination of the...	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
43252	Esophagogastroduodenoscopy, flexible, transoral; with optical endomicroscopy	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
43253	Esophagogastroduodenoscopy, flexible, transoral; with transendoscopic ultrasound-guided transmural injection of diagnostic or therapeutic substance(s) (eg, anesthetic, neurolytic agent) or fiducia...	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
43259	Esophagogastroduodenoscopy, flexible, transoral; with endoscopic ultrasound examination, including the esophagus, stomach, and either the duodenum or a surgically altered stomach where the jejunum...	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
43280	Laparoscopy, surgical, esophagogastric fundoplasty (eg, Nissen, Toupet procedures)	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
43281	Laparoscopy, surgical, repair of paraesophageal hernia, includes fundoplasty, when performed; without implantation of mesh	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
43282	Laparoscopy, surgical, repair of paraesophageal hernia, includes fundoplasty, when performed; with implantation of mesh	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
43284	Laparoscopy, surgical, esophageal sphincter augmentation procedure, placement of sphincter augmentation device (ie, magnetic band), including cruroplasty when performed	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
43647	Laparoscopy, surgical; implantation or replacement of gastric neurostimulator electrodes, antrum	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
43648	Laparoscopy, surgical; revision or removal of gastric neurostimulator electrodes, antrum	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
43881	Implantation or replacement of gastric neurostimulator electrodes, antrum, open	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
43882	Revision or removal of gastric neurostimulator electrodes, antrum, open	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
64582	Open implantation of hypoglossal nerve neurostimulator array, pulse generator, and distal respiratory sensor electrode or electrode array	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
64583	REVISION OR REPLACEMENT OF HYPOGLOSSAL NERVE NEUROSTIMULATOR ARRAY AND DISTAL RESPIRATORY SENSOR ELECTRODE OR ELECTRODE ARRAY, INCLUDING CONNECTION TO EXISTING PULSE GENERATOR	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
64584	REMOVAL OF HYPOGLOSSAL NERVE NEUROSTIMULATOR ARRAY, PULSE GENERATOR, AND DISTAL RESPIRATORY SENSOR ELECTRODE OR ELECTRODE ARRAY	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
70336	Magnetic resonance (eg, proton) imaging, temporomandibular joint(s)	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
70450	Computed tomography, head or brain; without contrast material	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
70460	Computed tomography, head or brain; with contrast material(s)	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
70470	Computed tomography, head or brain; without contrast material, followed by contrast material(s) and further sections	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
70480	Computed tomography, orbit, sella, or posterior fossa or outer, middle, or inner ear; without contrast material	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
70481	Computed tomography, orbit, sella, or posterior fossa or outer, middle, or inner ear; with contrast material(s)	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
70482	Computed tomography, orbit, sella, or posterior fossa or outer, middle, or inner ear; without contrast material, followed by contrast material(s) and further sections	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
70486	Computed tomography, maxillofacial area; without contrast material	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
70487	Computed tomography, maxillofacial area; with contrast material(s)	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
70488	Computed tomography, maxillofacial area; without contrast material, followed by contrast material(s) and further sections	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
70490	Computed tomography, soft tissue neck; without contrast material	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
70491	Computed tomography, soft tissue neck; with contrast material(s)	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	

Codes	Code Description	Medical Mutual Commercial	Medical Mutual Commercial Criteria	Medicare Advantage	Medicare Advantage Criteria	Details/Notes
70492	Computed tomography, soft tissue neck; without contrast material followed by contrast material(s) and further sections	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
70496	Computed tomographic angiography, head, with contrast material(s), including noncontrast images, if performed, and image postprocessing	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
70498	Computed tomographic angiography, neck, with contrast material(s), including noncontrast images, if performed, and image postprocessing	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
70540	Magnetic resonance (eg, proton) imaging, orbit, face, and/or neck; without contrast material(s)	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
70542	Magnetic resonance (eg, proton) imaging, orbit, face, and/or neck; with contrast material(s)	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
70543	Magnetic resonance (eg, proton) imaging, orbit, face, and/or neck; without contrast material(s), followed by contrast material(s) and further sequences	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
70544	Magnetic resonance angiography, head; without contrast material(s)	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
70545	Magnetic resonance angiography, head; with contrast material(s)	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
70546	Magnetic resonance angiography, head; without contrast material(s), followed by contrast material(s) and further sequences	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
70547	Magnetic resonance angiography, neck; without contrast material(s)	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
70548	Magnetic resonance angiography, neck; with contrast material(s)	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
70549	Magnetic resonance angiography, neck; without contrast material(s), followed by contrast material(s) and further sequences	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
70551	Magnetic resonance (eg, proton) imaging, brain (including brain stem); without contrast material	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
70552	Magnetic resonance (eg, proton) imaging, brain (including brain stem); with contrast material(s)	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
70553	Magnetic resonance (eg, proton) imaging, brain (including brain stem); without contrast material, followed by contrast material(s) and further sequences	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
70554	Magnetic resonance imaging, brain, functional MRI; including test selection and administration of repetitive body part movement and/or visual stimulation, not requiring physician or psychologist a...	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
70555	Magnetic resonance imaging, brain, functional MRI; requiring physician or psychologist administration of entire neurofunctional testing	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
71250	Computed tomography, thorax, diagnostic; without contrast material	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
71260	Computed tomography, thorax, diagnostic; with contrast material(s)	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
71270	Computed tomography, thorax, diagnostic; without contrast material, followed by contrast material(s) and further sections	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
71271	Computed tomography, thorax, low dose for lung cancer screening, without contrast material(s)	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
71275	Computed tomographic angiography, chest (noncoronary), with contrast material(s), including noncontrast images, if performed, and image postprocessing	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
71550	Magnetic resonance (eg, proton) imaging, chest (eg, for evaluation of hilar and mediastinal lymphadenopathy); without contrast material(s)	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
71551	Magnetic resonance (eg, proton) imaging, chest (eg, for evaluation of hilar and mediastinal lymphadenopathy); with contrast material(s)	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
71552	Magnetic resonance (eg, proton) imaging, chest (eg, for evaluation of hilar and mediastinal lymphadenopathy); without contrast material(s), followed by contrast material(s) and further sequences	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
71555	Magnetic resonance angiography, chest (excluding myocardium), with or without contrast material(s)	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
72125	Computed tomography, cervical spine; without contrast material	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
72126	Computed tomography, cervical spine; with contrast material	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
72127	Computed tomography, cervical spine; without contrast material, followed by contrast material(s) and further sections	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	

Codes	Code Description	Medical Mutual Commercial	Medical Mutual Commercial Criteria	Medicare Advantage	Medicare Advantage Criteria	Details/Notes
72128	Computed tomography, thoracic spine; without contrast material	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
72129	Computed tomography, thoracic spine; with contrast material	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
72130	Computed tomography, thoracic spine; without contrast material, followed by contrast material(s) and further sections	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
72131	Computed tomography, lumbar spine; without contrast material	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
72132	Computed tomography, lumbar spine; with contrast material	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
72133	Computed tomography, lumbar spine; without contrast material, followed by contrast material(s) and further sections	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
72141	Magnetic resonance (eg, proton) imaging, spinal canal and contents, cervical; without contrast material	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
72142	Magnetic resonance (eg, proton) imaging, spinal canal and contents, cervical; with contrast material(s)	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
72146	Magnetic resonance (eg, proton) imaging, spinal canal and contents, thoracic; without contrast material	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
72147	Magnetic resonance (eg, proton) imaging, spinal canal and contents, thoracic; with contrast material(s)	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
72148	Magnetic resonance (eg, proton) imaging, spinal canal and contents, lumbar; without contrast material	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
72149	Magnetic resonance (eg, proton) imaging, spinal canal and contents, lumbar; with contrast material(s)	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
72156	Magnetic resonance (eg, proton) imaging, spinal canal and contents, without contrast material, followed by contrast material(s) and further sequences; cervical	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
72157	Magnetic resonance (eg, proton) imaging, spinal canal and contents, without contrast material, followed by contrast material(s) and further sequences; thoracic	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
72158	Magnetic resonance (eg, proton) imaging, spinal canal and contents, without contrast material, followed by contrast material(s) and further sequences; lumbar	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
72159	Magnetic resonance angiography, spinal canal and contents, with or without contrast material(s)	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
72191	Computed tomographic angiography, pelvis, with contrast material(s), including noncontrast images, if performed, and image postprocessing	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
72192	Computed tomography, pelvis; without contrast material	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
72193	Computed tomography, pelvis; with contrast material(s)	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
72194	Computed tomography, pelvis; without contrast material, followed by contrast material(s) and further sections	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
72195	Magnetic resonance (eg, proton) imaging, pelvis; without contrast material(s)	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
72196	Magnetic resonance (eg, proton) imaging, pelvis; with contrast material(s)	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
72197	Magnetic resonance (eg, proton) imaging, pelvis; without contrast material(s), followed by contrast material(s) and further sequences	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
72198	Magnetic resonance angiography, pelvis, with or without contrast material(s)	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
73200	Computed tomography, upper extremity; without contrast material	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
73201	Computed tomography, upper extremity; with contrast material(s)	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
73202	Computed tomography, upper extremity; without contrast material, followed by contrast material(s) and further sections	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
73206	Computed tomographic angiography, upper extremity, with contrast material(s), including noncontrast images, if performed, and image postprocessing	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
73218	Magnetic resonance (eg, proton) imaging, upper extremity, other than joint; without contrast material(s)	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	

Codes	Code Description	Medical Mutual Commercial	Medical Mutual Commercial Criteria	Medicare Advantage	Medicare Advantage Criteria	Details/Notes
73219	Magnetic resonance (eg, proton) imaging, upper extremity, other than joint; with contrast material(s)	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
73220	Magnetic resonance (eg, proton) imaging, upper extremity, other than joint; without contrast material(s), followed by contrast material(s) and further sequences	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
73221	Magnetic resonance (eg, proton) imaging, any joint of upper extremity; without contrast material(s)	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
73222	Magnetic resonance (eg, proton) imaging, any joint of upper extremity; with contrast material(s)	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
73223	Magnetic resonance (eg, proton) imaging, any joint of upper extremity; without contrast material(s), followed by contrast material(s) and further sequences	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
73225	Magnetic resonance angiography, upper extremity, with or without contrast material(s)	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
73700	Computed tomography, lower extremity; without contrast material	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
73701	Computed tomography, lower extremity; with contrast material(s)	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
73702	Computed tomography, lower extremity; without contrast material, followed by contrast material(s) and further sections	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
73706	Computed tomographic angiography, lower extremity, with contrast material(s), including noncontrast images, if performed, and image postprocessing	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
73718	Magnetic resonance (eg, proton) imaging, lower extremity other than joint; without contrast material(s)	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
73719	Magnetic resonance (eg, proton) imaging, lower extremity other than joint; with contrast material(s)	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
73720	Magnetic resonance (eg, proton) imaging, lower extremity other than joint; without contrast material(s), followed by contrast material(s) and further sequences	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
73721	Magnetic resonance (eg, proton) imaging, any joint of lower extremity; without contrast material	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
73722	Magnetic resonance (eg, proton) imaging, any joint of lower extremity; with contrast material(s)	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
73723	Magnetic resonance (eg, proton) imaging, any joint of lower extremity; without contrast material(s), followed by contrast material(s) and further sequences	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
73725	Magnetic resonance angiography, lower extremity, with or without contrast material(s)	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
74150	Computed tomography, abdomen; without contrast material	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
74160	Computed tomography, abdomen; with contrast material(s)	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
74170	Computed tomography, abdomen; without contrast material, followed by contrast material(s) and further sections	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
74174	Computed tomographic angiography, abdomen and pelvis, with contrast material(s), including noncontrast images, if performed, and image postprocessing	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
74175	Computed tomographic angiography, abdomen, with contrast material(s), including noncontrast images, if performed, and image postprocessing	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
74176	Computed tomography, abdomen and pelvis; without contrast material	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
74177	Computed tomography, abdomen and pelvis; with contrast material(s)	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
74178	Computed tomography, abdomen and pelvis; without contrast material in one or both body regions, followed by contrast material(s) and further sections in one or both body regions	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
74181	Magnetic resonance (eg, proton) imaging, abdomen; without contrast material(s)	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
74182	Magnetic resonance (eg, proton) imaging, abdomen; with contrast material(s)	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
74183	Magnetic resonance (eg, proton) imaging, abdomen; without contrast material(s), followed by with contrast material(s) and further sequences	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	

Codes	Code Description	Medical Mutual Commercial	Medical Mutual Commercial Criteria	Medicare Advantage	Medicare Advantage Criteria	Details/Notes
74185	Magnetic resonance angiography, abdomen, with or without contrast material(s)	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
74261	Computed tomographic (CT) colonography, diagnostic, including image postprocessing; without contrast material	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
74262	Computed tomographic (CT) colonography, diagnostic, including image postprocessing; with contrast material(s) including non-contrast images, if performed	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
74263	Computed tomographic (CT) colonography, screening, including image postprocessing	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
74712	Magnetic resonance (eg, proton) imaging, fetal, including placental and maternal pelvic imaging when performed; single or first gestation	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
74713	Magnetic resonance (eg, proton) imaging, fetal, including placental and maternal pelvic imaging when performed; each additional gestation (List separately in addition to code for primary procedure)	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
75557	Cardiac magnetic resonance imaging for morphology and function without contrast material;	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
75559	Cardiac magnetic resonance imaging for morphology and function without contrast material; with stress imaging	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
75561	Cardiac magnetic resonance imaging for morphology and function without contrast material(s), followed by contrast material(s) and further sequences;	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
75563	Cardiac magnetic resonance imaging for morphology and function without contrast material(s), followed by contrast material(s) and further sequences; with stress imaging	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
75571	Computed tomography, heart, without contrast material, with quantitative evaluation of coronary calcium	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
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 ...	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
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 ...	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
75574	Computed tomographic angiography, heart, coronary arteries and bypass grafts (when present), with contrast material, including 3D image postprocessing (including evaluation of cardiac structure an...	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
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 ...	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
75635	Computed tomographic angiography, abdominal aorta and bilateral iliofemoral lower extremity runoff, with contrast material(s), including noncontrast images, if performed, and image postprocessing	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
76376	3D rendering with interpretation and reporting of computed tomography, magnetic resonance imaging, ultrasound, or other tomographic modality with image postprocessing under concurrent supervision;...	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
76377	3D rendering with interpretation and reporting of computed tomography, magnetic resonance imaging, ultrasound, or other tomographic modality with image postprocessing under concurrent supervision;...	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
76380	Computed tomography, limited or localized follow-up study	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
76390	Magnetic resonance spectroscopy	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
76391	Magnetic resonance (eg, vibration) elastography	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
77046	Magnetic resonance imaging, breast, without contrast material; unilateral	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
77047	Magnetic resonance imaging, breast, without contrast material; bilateral	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
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 ...	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
77049	Magnetic resonance imaging, breast, without and with contrast material(s), including computer-aided detection (CAD real-time lesion detection, characterization and pharmacokinetic analysis), when ...	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	

Codes	Code Description	Medical Mutual Commercial	Medical Mutual Commercial Criteria	Medicare Advantage	Medicare Advantage Criteria	Details/Notes
77078	Computed tomography, bone mineral density study, 1 or more sites, axial skeleton (eg, hips, pelvis, spine)	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
77084	Magnetic resonance (eg, proton) imaging, bone marrow blood supply	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
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 concurrent...	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
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 (exercis...	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
78431	Myocardial imaging, positron emission tomography (PET), perfusion study (including ventricular wall motion[s] and/or ejection fraction[s], when performed); multiple studies at rest and stress (exe...	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
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 ...	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
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 ...	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
78451	Myocardial perfusion imaging, tomographic (SPECT) (including attenuation correction, qualitative or quantitative wall motion, ejection fraction by first pass or gated technique, additional quantif...	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
78452	Myocardial perfusion imaging, tomographic (SPECT) (including attenuation correction, qualitative or quantitative wall motion, ejection fraction by first pass or gated technique, additional quantif...	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
78453	Myocardial perfusion imaging, planar (including qualitative or quantitative wall motion, ejection fraction by first pass or gated technique, additional quantification, when performed); single stud...	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
78454	Myocardial perfusion imaging, planar (including qualitative or quantitative wall motion, ejection fraction by first pass or gated technique, additional quantification, when performed); multiple st...	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
78459	Myocardial imaging, positron emission tomography (PET), metabolic evaluation study (including ventricular wall motion[s] and/or ejection fraction[s], when performed), single study;	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
78466	Myocardial imaging, infarct avid, planar; qualitative or quantitative	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
78468	Myocardial imaging, infarct avid, planar; with ejection fraction by first pass technique	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
78469	Myocardial imaging, infarct avid, planar; tomographic SPECT with or without quantification	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
78472	Cardiac blood pool imaging, gated equilibrium; planar, single study at rest or stress (exercise and/or pharmacologic), wall motion study plus ejection fraction, with or without additional quantita...	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
78473	Cardiac blood pool imaging, gated equilibrium; multiple studies, wall motion study plus ejection fraction, at rest and stress (exercise and/or pharmacologic), with or without additional quantifica...	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
78481	Cardiac blood pool imaging (planar), first pass technique; single study, at rest or with stress (exercise and/or pharmacologic), wall motion study plus ejection fraction, with or without quantific...	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
78483	Cardiac blood pool imaging (planar), first pass technique; multiple studies, at rest and with stress (exercise and/or pharmacologic), wall motion study plus ejection fraction, with or without quan...	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
78491	Myocardial imaging, positron emission tomography (PET), perfusion study (including ventricular wall motion[s] and/or ejection fraction[s], when performed); single study, at rest or stress (exercis...	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
78492	Myocardial imaging, positron emission tomography (PET), perfusion study (including ventricular wall motion[s] and/or ejection fraction[s], when performed); multiple studies at rest and stress (exe...	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
78494	Cardiac blood pool imaging, gated equilibrium, SPECT, at rest, wall motion study plus ejection fraction, with or without quantitative processing	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
78608	Brain imaging, positron emission tomography (PET); metabolic evaluation	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	

Codes	Code Description	Medical Mutual Commercial	Medical Mutual Commercial Criteria	Medicare Advantage	Medicare Advantage Criteria	Details/Notes
78609	Brain imaging, positron emission tomography (PET); perfusion evaluation	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
78811	Positron emission tomography (PET) imaging; limited area (eg, chest, head/neck)	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
78812	Positron emission tomography (PET) imaging; skull base to mid-thigh	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
78813	Positron emission tomography (PET) imaging; whole body	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
78814	Positron emission tomography (PET) with concurrently acquired computed tomography (CT) for attenuation correction and anatomical localization imaging; limited area (eg, chest, head/neck)	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
78815	Positron emission tomography (PET) with concurrently acquired computed tomography (CT) for attenuation correction and anatomical localization imaging; skull base to mid-thigh	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
78816	Positron emission tomography (PET) with concurrently acquired computed tomography (CT) for attenuation correction and anatomical localization imaging; whole body	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
91110	Gastrointestinal tract imaging, intraluminal (eg, capsule endoscopy), esophagus through ileum, with interpretation and report	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
91111	Gastrointestinal tract imaging, intraluminal (eg, capsule endoscopy), esophagus with interpretation and report	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
91113	Gastrointestinal tract imaging, intraluminal (eg, capsule endoscopy), colon, with interpretation and report	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
92507	Treatment of speech, language, voice, communication, and/or auditory processing disorder; individual	Not all plans require prior approval for therapy services. Please contact the number listed on the Covered Person's ID card.	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION NOT REQUIRED		
92508	Treatment of speech, language, voice, communication, and/or auditory processing disorder; group, 2 or more individuals	Not all plans require prior approval for therapy services. Please contact the number listed on the Covered Person's ID card.	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION NOT REQUIRED		
92521	Evaluation of speech fluency (eg, stuttering, cluttering)	Not all plans require prior approval for therapy services. Please contact the number listed on the Covered Person's ID card.	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION NOT REQUIRED		
92522	Evaluation of speech sound production (eg, articulation, phonological process, apraxia, dysarthria);	Not all plans require prior approval for therapy services. Please contact the number listed on the Covered Person's ID card.	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION NOT REQUIRED		
92523	Evaluation of speech sound production (eg, articulation, phonological process, apraxia, dysarthria); with evaluation of language comprehension and expression (eg, receptive and expressive language)	Not all plans require prior approval for therapy services. Please contact the number listed on the Covered Person's ID card.	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION NOT REQUIRED		
92524	Behavioral and qualitative analysis of voice and resonance	Not all plans require prior approval for therapy services. Please contact the number listed on the Covered Person's ID card.	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION NOT REQUIRED		
92526	Treatment of swallowing dysfunction and/or oral function for feeding	Not all plans require prior approval for therapy services. Please contact the number listed on the Covered Person's ID card.	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION NOT REQUIRED		
92610	Evaluation of oral and pharyngeal swallowing function	Not all plans require prior approval for therapy services. Please contact the number listed on the Covered Person's ID card.	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION NOT REQUIRED		
92611	Motion fluoroscopic evaluation of swallowing function by cine or video recording	Not all plans require prior approval for therapy services. Please contact the number listed on the Covered Person's ID card.	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION NOT REQUIRED		
92920	Percutaneous transluminal coronary angioplasty; single major coronary artery or branch	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	

Codes	Code Description	Medical Mutual Commercial	Medical Mutual Commercial Criteria	Medicare Advantage	Medicare Advantage Criteria	Details/Notes
92924	Percutaneous transluminal coronary atherectomy, with coronary angioplasty when performed; single major coronary artery or branch	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
92928	Percutaneous transcatheter placement of intracoronary stent(s), with coronary angioplasty when performed; single major coronary artery or branch	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
92933	Percutaneous transluminal coronary atherectomy, with intracoronary stent, with coronary angioplasty when performed; single major coronary artery or branch	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
92937	Percutaneous transluminal revascularization of or through coronary artery bypass graft (internal mammary, free arterial, venous), any combination of intracoronary stent, atherectomy and angioplast...	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
92943	Percutaneous transluminal revascularization of chronic total occlusion, coronary artery, coronary artery branch, or coronary artery bypass graft, any combination of intracoronary stent, atherectom...	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
92972	Percutaneous transluminal coronary lithotripsy (List separately in addition to code for primary procedure)	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
93150	Therapy activation of implanted phrenic nerve stimulator system, including all interrogation and programming	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
93151	Interrogation and programming (minimum one parameter) of implanted phrenic nerve stimulator system	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
93152	Interrogation and programming of implanted phrenic nerve stimulator system during polysomnography	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
93153	Interrogation without programming of implanted phrenic nerve stimulator system	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
93228	External mobile cardiovascular telemetry with electrocardiographic recording, concurrent computerized real time data analysis and greater than 24 hours of accessible ECG data storage (retrievable ...	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
93229	External mobile cardiovascular telemetry with electrocardiographic recording, concurrent computerized real time data analysis and greater than 24 hours of accessible ECG data storage (retrievable ...	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
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 REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
93451	Right heart catheterization including measurement(s) of oxygen saturation and cardiac output, when performed	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
93452	Left heart catheterization including intraprocedural injection(s) for left ventriculography, imaging supervision and interpretation, when performed	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
93453	Combined right and left heart catheterization including intraprocedural injection(s) for left ventriculography, imaging supervision and interpretation, when performed	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
93454	Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation;	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
93455	Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with catheter placement(...	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
93456	Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with right heart cathete...	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
93457	Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with catheter placement(...	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
93458	Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with left heart catheter...	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
93459	Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with left heart catheter...	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
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 hear...	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	

Codes	Code Description	Medical Mutual Commercial	Medical Mutual Commercial Criteria	Medicare Advantage	Medicare Advantage Criteria	Details/Notes
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 hear...	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
93580	Percutaneous transcatheter closure of congenital interatrial communication (ie, Fontan fenestration, atrial septal defect) with implant	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
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 REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
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 REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
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 REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
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 REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
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); abnormal native connections	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
93600	Bundle of His recording	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
93602	Intra-atrial recording	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
93603	Right ventricular recording	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
93610	Intra-atrial pacing	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
93612	Intraventricular pacing	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
93618	Induction of arrhythmia by electrical pacing	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
93619	Comprehensive electrophysiologic evaluation with right atrial pacing and recording, right ventricular pacing and recording, His bundle recording, including insertion and repositioning of multiple ...	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
93620	Comprehensive electrophysiologic evaluation including insertion and repositioning of multiple electrode catheters with induction or attempted induction of arrhythmia; with right atrial pacing and ...	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
93624	Electrophysiologic follow-up study with pacing and recording to test effectiveness of therapy, including induction or attempted induction of arrhythmia	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
93631	Intra-operative epicardial and endocardial pacing and mapping to localize the site of tachycardia or zone of slow conduction for surgical correction	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
93640	Electrophysiologic evaluation of single or dual chamber pacing cardioverter-defibrillator leads including defibrillation threshold evaluation (induction of arrhythmia, evaluation of sensing and pa...	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
93641	Electrophysiologic evaluation of single or dual chamber pacing cardioverter-defibrillator leads including defibrillation threshold evaluation (induction of arrhythmia, evaluation of sensing and pa...	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
93642	Electrophysiologic evaluation of single or dual chamber transvenous pacing cardioverter-defibrillator (includes defibrillation threshold evaluation, induction of arrhythmia, evaluation of sensing ...	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
93644	Electrophysiologic evaluation of subcutaneous implantable defibrillator (includes defibrillation threshold evaluation, induction of arrhythmia, evaluation of sensing for arrhythmia termination, an...	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
93650	Intracardiac catheter ablation of atrioventricular node function, atrioventricular conduction for creation of complete heart block, with or without temporary pacemaker placement	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
93653	Comprehensive electrophysiologic evaluation with insertion and repositioning of multiple electrode catheters, induction or attempted induction of an arrhythmia with right atrial pacing and recordi...	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	

Codes	Code Description	Medical Mutual Commercial	Medical Mutual Commercial Criteria	Medicare Advantage	Medicare Advantage Criteria	Details/Notes
93654	Comprehensive electrophysiologic evaluation with insertion and repositioning of multiple electrode catheters, induction or attempted induction of an arrhythmia with right atrial pacing and recordi...	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
93656	Comprehensive electrophysiologic evaluation including transseptal catheterizations, insertion and repositioning of multiple electrode catheters with intracardiac catheter ablation of atrial fibril...	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
93745	Initial set-up and programming by a physician or other qualified health care professional of wearable cardioverter-defibrillator includes initial programming of system, establishing baseline elect...	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
95782	Polysomnography; younger than 6 years, sleep staging with 4 or more additional parameters of sleep, attended by a technologist	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
95783	Polysomnography; younger than 6 years, sleep staging with 4 or more additional parameters of sleep, with initiation of continuous positive airway pressure therapy or bi-level ventilation, attended...	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
95800	Sleep study, unattended, simultaneous recording; heart rate, oxygen saturation, respiratory analysis (eg, by airflow or peripheral arterial tone), and sleep time	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
95801	Sleep study, unattended, simultaneous recording; minimum of heart rate, oxygen saturation, and respiratory analysis (eg, by airflow or peripheral arterial tone)	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
95805	Multiple sleep latency or maintece of wakefulness testing, recording, analysis and interpretation of physiological measurements of sleep during multiple trials to assess sleepiness	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
95806	Sleep study, unattended, simultaneous recording of, heart rate, oxygen saturation, respiratory airflow, and respiratory effort (eg, thoracoabdominal movement)	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
95807	Sleep study, simultaneous recording of ventilation, respiratory effort, ECG or heart rate, and oxygen saturation, attended by a technologist	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
95808	Polysomnography; any age, sleep staging with 1-3 additional parameters of sleep, attended by a technologist	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
95810	Polysomnography; age 6 years or older, sleep staging with 4 or more additional parameters of sleep, attended by a technologist	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
95811	Polysomnography; age 6 years or older, sleep staging with 4 or more additional parameters of sleep, with initiation of continuous positive airway pressure therapy or bilevel ventilation, attended ...	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
96105	Assessment of aphasia (includes assessment of expressive and receptive speech and language function, language comprehension, speech production ability, reading, spelling, writing, eg, by Boston Di...	Not all plans require prior approval for therapy services. Please contact the number listed on the Covered Person's ID card.	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION NOT REQUIRED		
97010	Application of a modality to 1 or more areas; hot or cold packs	Not all plans require prior approval for therapy services. Please contact the number listed on the Covered Person's ID card.	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION NOT REQUIRED		
97012	Application of a modality to 1 or more areas; traction, mechanical	Not all plans require prior approval for therapy services. Please contact the number listed on the Covered Person's ID card.	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION NOT REQUIRED		
97014	Application of a modality to 1 or more areas; electrical stimulation (unattended)	Not all plans require prior approval for therapy services. Please contact the number listed on the Covered Person's ID card.	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION NOT REQUIRED		
97016	Application of a modality to 1 or more areas; vasopneumatic devices	Not all plans require prior approval for therapy services. Please contact the number listed on the Covered Person's ID card.	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION NOT REQUIRED		
97018	Application of a modality to 1 or more areas; paraffin bath	Not all plans require prior approval for therapy services. Please contact the number listed on the Covered Person's ID card.	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION NOT REQUIRED		

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97022	Application of a modality to 1 or more areas; whirlpool	Not all plans require prior approval for therapy services. Please contact the number listed on the Covered Person's ID card.	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION NOT REQUIRED		
97024	Application of a modality to 1 or more areas; diathermy (eg, microwave)	Not all plans require prior approval for therapy services. Please contact the number listed on the Covered Person's ID card.	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION NOT REQUIRED		
97026	Application of a modality to 1 or more areas; infrared	Not all plans require prior approval for therapy services. Please contact the number listed on the Covered Person's ID card.	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION NOT REQUIRED		
97028	Application of a modality to 1 or more areas; ultraviolet	Not all plans require prior approval for therapy services. Please contact the number listed on the Covered Person's ID card.	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION NOT REQUIRED		
97032	Application of a modality to 1 or more areas; electrical stimulation (manual), each 15 minutes	Not all plans require prior approval for therapy services. Please contact the number listed on the Covered Person's ID card.	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION NOT REQUIRED		
97033	Application of a modality to 1 or more areas; iontophoresis, each 15 minutes	Not all plans require prior approval for therapy services. Please contact the number listed on the Covered Person's ID card.	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION NOT REQUIRED		
97034	Application of a modality to 1 or more areas; contrast baths, each 15 minutes	Not all plans require prior approval for therapy services. Please contact the number listed on the Covered Person's ID card.	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION NOT REQUIRED		
97035	Application of a modality to 1 or more areas; ultrasound, each 15 minutes	Not all plans require prior approval for therapy services. Please contact the number listed on the Covered Person's ID card.	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION NOT REQUIRED		
97036	Application of a modality to 1 or more areas; Hubbard tank, each 15 minutes	Not all plans require prior approval for therapy services. Please contact the number listed on the Covered Person's ID card.	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION NOT REQUIRED		
97039	Unlisted modality (specify type and time if constant attendance)	Not all plans require prior approval for therapy services. Please contact the number listed on the Covered Person's ID card.	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION NOT REQUIRED		
97110	Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility	Not all plans require prior approval for therapy services. Please contact the number listed on the Covered Person's ID card.	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION NOT REQUIRED		
97112	Therapeutic procedure, 1 or more areas, each 15 minutes; neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing...	Not all plans require prior approval for therapy services. Please contact the number listed on the Covered Person's ID card.	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION NOT REQUIRED		
97113	Therapeutic procedure, 1 or more areas, each 15 minutes; aquatic therapy with therapeutic exercises	Not all plans require prior approval for therapy services. Please contact the number listed on the Covered Person's ID card.	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION NOT REQUIRED		
97116	Therapeutic procedure, 1 or more areas, each 15 minutes; gait training (includes stair climbing)	Not all plans require prior approval for therapy services. Please contact the number listed on the Covered Person's ID card.	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION NOT REQUIRED		
97124	Therapeutic procedure, 1 or more areas, each 15 minutes; massage, including effleurage, petrissage and/or tapotement (stroking, compression, percussion)	Not all plans require prior approval for therapy services. Please contact the number listed on the Covered Person's ID card.	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION NOT REQUIRED		

Codes	Code Description	Medical Mutual Commercial	Medical Mutual Commercial Criteria	Medicare Advantage	Medicare Advantage Criteria	Details/Notes
97129	Therapeutic interventions that focus on cognitive function (eg, attention, memory, reasoning, executive function, problem solving, and/or pragmatic functioning) and compensatory strategies to mana...	Not all plans require prior approval for therapy services. Please contact the number listed on the Covered Person's ID card.	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION NOT REQUIRED		
97139	Unlisted therapeutic procedure (specify)	Not all plans require prior approval for therapy services. Please contact the number listed on the Covered Person's ID card.	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION NOT REQUIRED		
97140	Manual therapy techniques (eg, mobilization/ manipulation, manual lymphatic drainage, manual traction), 1 or more regions, each 15 minutes	Not all plans require prior approval for therapy services. Please contact the number listed on the Covered Person's ID card.	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION NOT REQUIRED		
97150	Therapeutic procedure(s), group (2 or more individuals)	Not all plans require prior approval for therapy services. Please contact the number listed on the Covered Person's ID card.	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION NOT REQUIRED		
97165	Occupational therapy evaluation, low complexity, requiring these components: An occupational profile and medical and therapy history, which includes a brief history including review of medical and...	Not all plans require prior approval for therapy services. Please contact the number listed on the Covered Person's ID card.	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION NOT REQUIRED		
97166	Occupational therapy evaluation, moderate complexity, requiring these components: An occupational profile and medical and therapy history, which includes an expanded review of medical and/or thera...	Not all plans require prior approval for therapy services. Please contact the number listed on the Covered Person's ID card.	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION NOT REQUIRED		
97167	Occupational therapy evaluation, high complexity, requiring these components: An occupational profile and medical and therapy history, which includes review of medical and/or therapy records and e...	Not all plans require prior approval for therapy services. Please contact the number listed on the Covered Person's ID card.	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION NOT REQUIRED		
97168	Re-evaluation of occupational therapy established plan of care, requiring these components: An assessment of changes in patient functional or medical status with revised plan of care; An update to...	Not all plans require prior approval for therapy services. Please contact the number listed on the Covered Person's ID card.	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION NOT REQUIRED		
97530	Therapeutic activities, direct (one-on-one) patient contact (use of dynamic activities to improve functional performance), each 15 minutes	Not all plans require prior approval for therapy services. Please contact the number listed on the Covered Person's ID card.	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION NOT REQUIRED		
97533	Sensory integrative techniques to enhance sensory processing and promote adaptive responses to environmental demands, direct (one-on-one) patient contact, each 15 minutes	Not all plans require prior approval for therapy services. Please contact the number listed on the Covered Person's ID card.	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION NOT REQUIRED		
97535	Self-care/home management training (eg, activities of daily living (ADL) and compensatory training, meal preparation, safety procedures, and instructions in use of assistive technology devices/ada...	Not all plans require prior approval for therapy services. Please contact the number listed on the Covered Person's ID card.	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION NOT REQUIRED		
97537	Community/work reintegration training (eg, shopping, transportation, money management, avocational activities and/or work environment/modification analysis, work task analysis, use of assistive te...	Not all plans require prior approval for therapy services. Please contact the number listed on the Covered Person's ID card.	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION NOT REQUIRED		
97542	Wheelchair management (eg, assessment, fitting, training), each 15 minutes	Not all plans require prior approval for therapy services. Please contact the number listed on the Covered Person's ID card.	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION NOT REQUIRED		
97545	Work hardening/conditioning; initial 2 hours	Not all plans require prior approval for therapy services. Please contact the number listed on the Covered Person's ID card.	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION NOT REQUIRED		
97546	Work hardening/conditioning; each additional hour (List separately in addition to code for primary procedure)	Not all plans require prior approval for therapy services. Please contact the number listed on the Covered Person's ID card.	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION NOT REQUIRED		

Codes	Code Description	Medical Mutual Commercial	Medical Mutual Commercial Criteria	Medicare Advantage	Medicare Advantage Criteria	Details/Notes
97602	Removal of devitalized tissue from wound(s), non-selective debridement, without anesthesia (eg, wet-to-moist dressings, enzymatic, abrasion, larval therapy), including topical application(s), woun...	Not all plans require prior approval for therapy services. Please contact the number listed on the Covered Person's ID card.	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION NOT REQUIRED		
97750	Physical performance test or measurement (eg, musculoskeletal, functional capacity), with written report, each 15 minutes	Not all plans require prior approval for therapy services. Please contact the number listed on the Covered Person's ID card.	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION NOT REQUIRED		
97755	Assistive technology assessment (eg, to restore, augment or compensate for existing function, optimize functional tasks and/or maximize environmental accessibility), direct one-on-one contact, wit...	Not all plans require prior approval for therapy services. Please contact the number listed on the Covered Person's ID card.	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION NOT REQUIRED		
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 ...	Not all plans require prior approval for therapy services. Please contact the number listed on the Covered Person's ID card.	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION NOT REQUIRED		
97761	Prosthetic(s) training, upper and/or lower extremity(ies), initial prosthetic(s) encounter, each 15 minutes	Not all plans require prior approval for therapy services. Please contact the number listed on the Covered Person's ID card.	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION NOT REQUIRED		
97763	Orthotic(s)/prosthetic(s) management and/or training, upper extremity(ies), lower extremity(ies), and/or trunk, subsequent orthotic(s)/prosthetic(s) encounter, each 15 minutes	Not all plans require prior approval for therapy services. Please contact the number listed on the Covered Person's ID card.	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION NOT REQUIRED		
97799	Unlisted physical medicine/rehabilitation service or procedure	Not all plans require prior approval for therapy services. Please contact the number listed on the Covered Person's ID card.	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION NOT REQUIRED		
98940	Chiropractic manipulative treatment (CMT); spinal, 1-2 regions	Not all plans require prior approval for therapy services. Please contact the number listed on the Covered Person's ID card.	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION NOT REQUIRED		
98941	Chiropractic manipulative treatment (CMT); spinal, 3-4 regions	Not all plans require prior approval for therapy services. Please contact the number listed on the Covered Person's ID card.	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION NOT REQUIRED		
98942	Chiropractic manipulative treatment (CMT); spinal, 5 regions	Not all plans require prior approval for therapy services. Please contact the number listed on the Covered Person's ID card.	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION NOT REQUIRED		
98943	Chiropractic manipulative treatment (CMT); extraspinal, 1 or more regions	Not all plans require prior approval for therapy services. Please contact the number listed on the Covered Person's ID card.	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION NOT REQUIRED		
0234T	Transluminal peripheral atherectomy, open or percutaneous, including radiological supervision and interpretation; renal artery	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
0235T	Transluminal peripheral atherectomy, open or percutaneous, including radiological supervision and interpretation; visceral artery (except renal), each vessel	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
0236T	Transluminal peripheral atherectomy, open or percutaneous, including radiological supervision and interpretation; abdominal aorta	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
0237T	Transluminal peripheral atherectomy, open or percutaneous, including radiological supervision and interpretation; brachiocephalic trunk and branches, each vessel	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
0238T	Transluminal peripheral atherectomy, open or percutaneous, including radiological supervision and interpretation; iliac artery, each vessel	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
0266T	Implantation or replacement of carotid sinus baroreflex activation device; total system (includes generator placement, unilateral or bilateral lead placement, intra-operative interrogation, progra...	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
0267T	Implantation or replacement of carotid sinus baroreflex activation device; lead only, unilateral (includes intra-operative interrogation, programming, and repositioning, when performed)	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	

Codes	Code Description	Medical Mutual Commercial	Medical Mutual Commercial Criteria	Medicare Advantage	Medicare Advantage Criteria	Details/Notes
0268T	Implantation or replacement of carotid sinus baroreflex activation device; pulse generator only (includes intra-operative interrogation, programming, and repositioning, when performed)	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
0269T	Revision or removal of carotid sinus baroreflex activation device; total system (includes generator placement, unilateral or bilateral lead placement, intra-operative interrogation, programming, a...	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
0270T	Revision or removal of carotid sinus baroreflex activation device; lead only, unilateral (includes intra-operative interrogation, programming, and repositioning, when performed)	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
0271T	Revision or removal of carotid sinus baroreflex activation device; pulse generator only (includes intra-operative interrogation, programming, and repositioning, when performed)	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
0272T	Interrogation device evaluation (in person), carotid sinus baroreflex activation system, including telemetric iterative communication with the implantable device to monitor device diagnostics and ...	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
0273T	Interrogation device evaluation (in person), carotid sinus baroreflex activation system, including telemetric iterative communication with the implantable device to monitor device diagnostics and ...	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
0345T	Transcatheter mitral valve repair percutaneous approach via the coronary sinus	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
0408T	Insertion or replacement of permanent cardiac contractility modulation system, including contractility evaluation when performed, and programming of sensing and therapeutic parameters; pulse gener...	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
0409T	Insertion or replacement of permanent cardiac contractility modulation system, including contractility evaluation when performed, and programming of sensing and therapeutic parameters; pulse gener...	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
0410T	Insertion or replacement of permanent cardiac contractility modulation system, including contractility evaluation when performed, and programming of sensing and therapeutic parameters; atrial elec...	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
0411T	Insertion or replacement of permanent cardiac contractility modulation system, including contractility evaluation when performed, and programming of sensing and therapeutic parameters; ventricular...	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
0412T	REMOVAL OF PERMANENT CARDIAC CONTRACTILITY MODULATION SYSTEM; PULSE GENERATOR ONLY	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
0413T	REMOVAL OF PERMANENT CARDIAC CONTRACTILITY MODULATION SYSTEM; TRANSVENOUS ELECTRODE (ATRIAL OR VENTRICULAR)	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
0414T	REMOVAL AND REPLACEMENT OF PERMANENT CARDIAC CONTRACTILITY MODULATION SYSTEM PULSE GENERATOR ONLY	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
0415T	Repositioning of previously implanted cardiac contractility modulation transvenous electrode (atrial or ventricular lead)	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
0416T	Relocation of skin pocket for implanted cardiac contractility modulation pulse generator	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
0417T	Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, inclu...	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
0418T	Interrogation device evaluation (in person) with analysis, review and report, includes connection, recording and disconnection per patient encounter, implantable cardiac contractility modulation s...	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
0505T	Endovenous femoral-popliteal arterial revascularization, with transcatheter placement of intravascular stent graft(s) and closure by any method, including percutaneous or open vascular access, ult...	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
0571T	Insertion or replacement of implantable cardioverter-defibrillator system with substernal electrode(s), including all imaging guidance and electrophysiological evaluation (includes defibrillation ...	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
0572T	Insertion of substernal implantable defibrillator electrode	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
0574T	Repositioning of previously implanted substernal implantable defibrillator-pacing electrode	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
0577T	Electrophysiologic evaluation of implantable cardioverter-defibrillator system with substernal electrode (includes defibrillation threshold evaluation, induction of arrhythmia, evaluation of sensi...	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	

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0651T	Magnetically controlled capsule endoscopy, esophagus through stomach, including intraprocedural positioning of capsule, with interpretation and report	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
C1721	Cardioverter-defibrillator, dual chamber (implantable)	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
C1722	Cardioverter-defibrillator, single chamber (implantable)	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
C1761	Catheter, transluminal intravascular lithotripsy, coronary	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
C1777	Lead, cardioverter-defibrillator, endocardial single coil (implantable)	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
C1779	Lead, pacemaker, transvenous vdd single pass	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
C1785	Pacemaker, dual chamber, rate-responsive (implantable)	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
C1786	Pacemaker, single chamber, rate-responsive (implantable)	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
C1825	Generator, neurostimulator (implantable), non-rechargeable with carotid sinus baroreceptor stimulation lead(s)	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
C1882	Cardioverter-defibrillator, other than single or dual chamber (implantable)	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
C1895	Lead, cardioverter-defibrillator, endocardial dual coil (implantable)	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
C1896	Lead, cardioverter-defibrillator, other than endocardial single or dual coil (implantable)	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
C1898	Lead, pacemaker, other than transvenous vdd single pass	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
C1899	Lead, pacemaker/cardioverter-defibrillator combination (implantable)	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
C1900	Lead, left ventricular coronary venous system	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
C2619	Pacemaker, dual chamber, non rate-responsive (implantable)	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
C2620	Pacemaker, single chamber, non rate-responsive (implantable)	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
C2621	Pacemaker, other than single or dual chamber (implantable)	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
C2624	Implantable wireless pulmonary artery pressure sensor with delivery catheter, including all system components	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
C8900	Magnetic resonance angiography with contrast, abdomen	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
C8901	Magnetic resonance angiography without contrast, abdomen	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
C8902	Magnetic resonance angiography without contrast followed by with contrast, abdomen	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
C8903	Magnetic resonance imaging with contrast, breast; unilateral	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
C8905	Magnetic resonance imaging without contrast followed by with contrast, breast; unilateral	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
C8906	Magnetic resonance imaging with contrast, breast; bilateral	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
C8908	Magnetic resonance imaging without contrast followed by with contrast, breast; bilateral	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
C8909	Magnetic resonance angiography with contrast, chest (excluding myocardium)	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
C8910	Magnetic resonance angiography without contrast, chest (excluding myocardium)	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
C8911	Magnetic resonance angiography without contrast followed by with contrast, chest (excluding myocardium)	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
C8912	Magnetic resonance angiography with contrast, lower extremity	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	

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C8913	Magnetic resonance angiography without contrast, lower extremity	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
C8914	Magnetic resonance angiography without contrast followed by with contrast, lower extremity	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
C8918	Magnetic resonance angiography with contrast, pelvis	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
C8919	Magnetic resonance angiography without contrast, pelvis	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
C8920	Magnetic resonance angiography without contrast followed by with contrast, pelvis	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
C8931	Magnetic resonance angiography with contrast, spinal canal and contents	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
C8932	Magnetic resonance angiography without contrast, spinal canal and contents	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
C8933	Magnetic resonance angiography without contrast followed by with contrast, spinal canal and contents	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
C8934	Magnetic resonance angiography with contrast, upper extremity	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
C8935	Magnetic resonance angiography without contrast, upper extremity	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
C8936	Magnetic resonance angiography without contrast followed by with contrast, upper extremity	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
C9600	Percutaneous transcatheter placement of drug eluting intracoronary stent(s), with coronary angioplasty when performed; single major coronary artery or branch	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
C9602	Percutaneous transluminal coronary atherectomy, with drug eluting intracoronary stent, with coronary angioplasty when performed; single major coronary artery or branch	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
C9604	Percutaneous transluminal revascularization of or through coronary artery bypass graft (internal mammary, free arterial, venous), any combination of drug-eluting intracoronary stent, atherectomy a...	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
C9607	Percutaneous transluminal revascularization of chronic total occlusion, coronary artery, coronary artery branch, or coronary artery bypass graft, any combination of drug-eluting intracoronary sten...	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
C9727	Insertion of implants into the soft palate; minimum of three implants	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
C9762	Cardiac magnetic resonance imaging for morphology and function, quantification of segmental dysfunction; with strain imaging	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
C9763	Cardiac magnetic resonance imaging for morphology and function, quantification of segmental dysfunction; with stress imaging	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
C9764	Revascularization, endovascular, open or percutaneous, lower extremity artery(ies), except tibial/peroneal; with intravascular lithotripsy, includes angioplasty within the same vessel(s), when per...	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
C9765	Revascularization, endovascular, open or percutaneous, lower extremity artery(ies), except tibial/peroneal; with intravascular lithotripsy, and transluminal stent placement(s), includes angioplast...	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
C9766	Revascularization, endovascular, open or percutaneous, lower extremity artery(ies), except tibial/peroneal; with intravascular lithotripsy and atherectomy, includes angioplasty within the same ves...	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
C9767	Revascularization, endovascular, open or percutaneous, lower extremity artery(ies), except tibial/peroneal; with intravascular lithotripsy and transluminal stent placement(s), and atherectomy, inc...	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
C9772	Revascularization, endovascular, open or percutaneous, tibial/peroneal artery(ies), with intravascular lithotripsy, includes angioplasty within the same vessel (s), when performed	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
C9773	Revascularization, endovascular, open or percutaneous, tibial/peroneal artery(ies); with intravascular lithotripsy, and transluminal stent placement(s), includes angioplasty within the same vess...	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
C9774	Revascularization, endovascular, open or percutaneous, tibial/peroneal artery(ies); with intravascular lithotripsy and atherectomy, includes angioplasty within the same vessel (s), when performed	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	

Codes	Code Description	Medical Mutual Commercial	Medical Mutual Commercial Criteria	Medicare Advantage	Medicare Advantage Criteria	Details/Notes
C9775	Revascularization, endovascular, open or percutaneous, tibial/peroneal artery(ies); with intravascular lithotripsy and transluminal stent placement(s), and atherectomy, includes angioplasty within...	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
C9791	Magnetic resonance imaging with inhaled hyperpolarized xenon-129 contrast agent, chest, including preparation and administration of agent	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
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 positi...	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
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...	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
E0485	Oral device/appliance used to reduce upper airway collapsibility, adjustable or non-adjustable, prefabricated, includes fitting and adjustment	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
E0486	Oral device/appliance used to reduce upper airway collapsibility, adjustable or non-adjustable, custom fabricated, includes fitting and adjustment	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
E0561	Humidifier, Nonheated, Used with Positive Airway Pressure Device	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
E0562	Humidifier, Heated, Used with Positive Airway Pressure Device	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
E0601	Continuous positive airway pressure (cpap) device	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
G0219	Pet imaging whole body; melanoma for non-covered indications	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
G0235	Pet imaging, any site, not otherwise specified	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
G0252	Pet imaging, full and partial-ring pet scanners only, for initial diagnosis of breast cancer and/or surgical planning for breast cancer (e.g., initial staging of axillary lymph nodes)	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
K0606	Automatic external defibrillator, with integrated electrocardiogram analysis, garment type	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
K0607	Replacement battery for automated external defibrillator, garment type only, each	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
K0608	Replacement garment for use with automated external defibrillator, each	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
K0609	Replacement electrodes for use with automated external defibrillator, garment type only, each	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
K1030	EXTERNAL RECHARGING SYSTEM FOR BATTERY (INTERNAL) FOR USE WITH IMPLANTED CARDIAC CONTRACTILITY MODULATION GENERATOR, REPLACEMENT ONLY	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
S2080	Laser-assisted uvulopalatoplasty (laup)	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
S8037	Magnetic resonance cholangiopancreatography (mrcp)	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
S8042	Magnetic resonance imaging (mri), low-field	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
S8092	Electron beam computed tomography (also known as ultrafast ct, cine ct)	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	

eviCore Delegated Codes

EviCore Healthcare Login: https://www.evicore.com/pages/providerlogin.aspx Phone: (888) 693-3211 Fax: (866) 699-8160

EviCore Review Criteria Guidelines: https://www.evicore.com/provider/clinical-guidelines

Codes	Code Description	Medical Mutual Commercial	Medical Mutual Commercial Criteria	Medicare Advantage	Medicare Advantage Criteria	Details/Notes
0394T	HDR electronic brachytherapy, skin surface application, per fraction	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
0395T	HDR electronic brachytherapy, interstitial or intracavitary treatment, per fraction	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
77761	Intracavitary radiation source application; simple	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	

Codes	Code Description	Medical Mutual Commercial	Medical Mutual Commercial Criteria	Medicare Advantage	Medicare Advantage Criteria	Details/Notes
77762	Intracavitary radiation source application; intermediate	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
77763	Intracavitary radiation source application; complex	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
77767	HDR radionuclide skin surface brachytherapy; lesion diameter up to 2.0 cm or 1 channel	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
77768	HDR radionuclide skin surface brachytherapy; lesion diameter over 2.0 cm and 2 or more channels, or multiple lesions	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
77770	HDR radionuclide interstitial or intracavitary brachytherapy; 1 channel	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
77771	HDR radionuclide rate interstitial or intracavitary brachytherapy; 2 to 12 channels	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
77772	HDR radionuclide interstitial or intracavitary brachytherapy; over 12 channels	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
77778	Interstitial radiation source application, complex, includes supervision, handling, loading of radiation source when performed	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
77789	Surface application of low dose rate radionuclide source	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
G0458	Low dose rate (LDR) prostate brachytherapy services, composite rate	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
0747T	Cardiac focal ablation utilizing radiation therapy for arrhythmia; delivery of radiation therapy, arrhythmia	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
77371	Radiation treatment delivery, stereotactic radiosurgery (SRS), complete course of treatment of cranial lesion(s) consisting of 1 session; multi-source Cobalt 60 based	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
77372	Radiation treatment delivery, stereotactic radiosurgery (SRS), complete course of treatment of cranial lesion(s) consisting of 1 session; linear accelerator based	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
77373	Stereotactic body radiation therapy, treatment delivery, per fraction to 1 or more lesions, including image guidance, entire course not to exceed 5 fractions	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
G0339	Image guided robotic linear accelerator-based stereotactic radiosurgery, complete course of therapy in one session or first session of fractionated treatment	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
G0340	Image guided robotic linear accelerator-based stereotactic radiosurgery, delivery including collimator changes and custom plugging, fractionated treatment, all lesions, per session, second through fifth sessions, maximum 5 sessions per course of treatment	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
77385	Intensity modulated radiation treatment delivery (IMRT), includes guidance and tracking, when performed; simple	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
77386	Intensity modulated radiation treatment delivery (IMRT), includes guidance and tracking, when performed; complex	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
G6015	Intensity modulated treatment delivery, single or multiple fields/arcs,via narrow spatially and temporally modulated beams, binary, dynamic mlc, per treatment session	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
G6016	Compensator-based beam modulation treatment delivery of inverse planned treatment using 3 or more high resolution (milled or cast) compensator, convergent beam modulated fields, per treatment session	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
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 REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
77424	Intraoperative radiation treatment delivery, x-ray, single treatment session	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
77425	Intraoperative radiation treatment delivery, electrons, single treatment session	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
77520	Proton treatment delivery; simple, without compensation	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
77522	Proton treatment delivery; simple, with compensation	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
77523	Proton treatment delivery; intermediate	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
77525	Proton treatment delivery; complex	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	

Codes	Code Description	Medical Mutual Commercial	Medical Mutual Commercial Criteria	Medicare Advantage	Medicare Advantage Criteria	Details/Notes
77600	Hyperthermia, externally generated; superficial (ie, heating to a depth of 4 cm or less)	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
77605	Hyperthermia, externally generated; deep (ie, heating to depths greater than 4 cm)	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
77610	Hyperthermia generated by interstitial probe(s); 5 or fewer interstitial applicators	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
77615	Hyperthermia generated by interstitial probe(s); more than 5 interstitial applicators	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
77620	Hyperthermia generated by intracavitary probe(s)	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
77401	Radiation treatment delivery, superficial and/or ortho voltage, per day	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
77402	Radiation treatment delivery, >1 MeV; simple	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
77407	Radiation treatment delivery; two separate treatment areas; three or more ports on a single treatment area; or three or more simple blocks;>=1 MeV; intermediate	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
77412	Radiation treatment delivery; three or more separate treatment areas; custom blocking; tangential ports; wedges; rotational beam; field-in-field or other tissue compensation that does not meet IMRT guidelines; or electron beam; >=1 MeV; complex	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
A9609	Injection, of fluorodeoxyglucose F18 FDG therapeutic, up to 15 millicuries	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
G0563	Stereotactic body radiation therapy, treatment delivery, per fraction to 1 or more lesions, including image guidance and real-time positron emissions-based delivery adjustments to 1 or more lesions, entire course not to exceed 5 fractions	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
G6003	Radiation treatment delivery, single treatment area,single port or parallel opposed ports, simple blocks or no blocks: up to 5mev	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
G6004	Radiation treatment delivery, single treatment area,single port or parallel opposed ports, simple blocks or no blocks: 6-10mev	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
G6005	Radiation treatment delivery, single treatment area,single port or parallel opposed ports, simple blocks or no blocks: 11-19mev	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
G6006	Radiation treatment delivery, single treatment area,single port or parallel opposed ports, simple blocks or no blocks: 20mev or greater	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
G6007	Radiation treatment delivery, 2 separate treatment areas, 3 or more ports on a single treatment area, use of multiple blocks: up to 5mev	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
G6008	Radiation treatment delivery, 2 separate treatment areas, 3 or more ports on a single treatment area, use of multiple blocks: 6-10mev	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
G6009	Radiation treatment delivery, 2 separate treatment areas, 3 or more ports on a single treatment area, use of multiple blocks: 11-19mev	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
G6010	Radiation treatment delivery, 2 separate treatment areas, 3 or more ports on a single treatment area, use of multiple blocks: 20 mev or greater	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
G6011	Radiation treatment delivery,3 or more separate treatment areas, custom blocking, tangential ports, wedges, rotational beam, compensators, electron beam; up to 5mev	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
G6012	Radiation treatment delivery,3 or more separate treatment areas, custom blocking, tangential ports, wedges, rotational beam, compensators, electron beam; 6-10mev	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
G6013	Radiation treatment delivery,3 or more separate treatment areas, custom blocking, tangential ports, wedges, rotational beam, compensators, electron beam; 11-19mev	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
G6014	Radiation treatment delivery,3 or more separate treatment areas, custom blocking, tangential ports, wedges, rotational beam, compensators, electron beam; 20mev or greater	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
77014	Computed tomography guidance for placement of radiation therapy fields	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
77387	Guidance for localization of target volume for delivery of radiation treatment, includes intrafraction tracking, when performed	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
G6001	Ultrasonic guidance for placement of radiation therapy fields	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	

Codes	Code Description	Medical Mutual Commercial	Medical Mutual Commercial Criteria	Medicare Advantage	Medicare Advantage Criteria	Details/Notes
G6002	Stereoscopic x-ray guidance for localization of target volume for the delivery of radiation therapy	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
G6017	Intra-fraction localization and tracking of target or patient motion during delivery of radiation therapy (eg, 3d positional tracking, gating, 3d surface tracking), each fraction of treatment	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
77750	Infusion or instillation of radioelement solution (includes 3-month follow-up care)	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
79005	Radiopharmaceutical therapy, by oral administration; used for I-131 treatment	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
A9699	Radiopharmaceutical, therapeutic, not otherwise classified	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
C2616	Brachytherapy source, nonstranded, yttrium-90, per source	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	
S2095	Transcatheter occlusion or embolization for tumor destruction, percutaneous, any method, using yttrium-90 microspheres	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	PRIOR AUTHORIZATION REQUIRED	Refer to Vendor Delegated link for criteria	

Investigational / Experimental / Not of Standard of Care

Codes	Code Description	Medical Mutual Commercial	Commercial Policy (CMP/MCG)	Medicare Advantage	Medicare Advantage Policy	Details/Notes
0528T	PROGRAMMING DEVICE EVALUATION (IN PERSON) OF INTRACARDIAC ISCHEMIA MONITORING SYSTEM WITH ITERATIVE ADJUSTMENT OF PROGRAMMED VALUES, WITH ANALYSIS, REVIEW, AND REPORT	NON-COVERED	CMP202406	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP202406	
0529T	INTERROGATION DEVICE EVALUATION (IN PERSON) OF INTRACARDIAC ISCHEMIA MONITORING SYSTEM WITH ANALYSIS, REVIEW, AND REPORT	NON-COVERED	CMP202406	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP202406	
0554T	BONE STRENGTH AND FRACTURE RISK USING FINITE ELEMENT ANALYSIS OF FUNCTIONAL DATA, AND BONE-MINERAL DENSITY, UTILIZING DATA FROM A COMPUTED TOMOGRAPHY SCAN; RETRIEVAL AND TRANSMISSION OF THE SCAN DATA, ASSESSMENT OF BONE STRENGTH AND FRACTURE RISK AND BONE MINERAL DENSITY, INTERPRETATION AND REPORT	NON-COVERED	CMP94022	PRIOR AUTHORIZATION NOT REQUIRED		
0556T	BONE STRENGTH AND FRACTURE RISK USING FINITE ELEMENT ANALYSIS OF FUNCTIONAL DATA, AND BONE-MINERAL DENSITY, UTILIZING DATA FROM A COMPUTED TOMOGRAPHY SCAN; ASSESSMENT OF BONE STRENGTH AND FRACTURE RISK AND BONE MINERAL DENSITY	NON-COVERED	CMP94022	PRIOR AUTHORIZATION NOT REQUIRED		
0557T	BONE STRENGTH AND FRACTURE RISK USING FINITE ELEMENT ANALYSIS OF FUNCTIONAL DATA, AND BONE-MINERAL DENSITY, UTILIZING DATA FROM A COMPUTED TOMOGRAPHY SCAN; INTERPRETATION AND REPORT	NON-COVERED	CMP94022	PRIOR AUTHORIZATION NOT REQUIRED		
0586T	ISLET CELL TRANSPLANT, INCLUDES PORTAL VEIN CATHETERIZATION AND INFUSION, INCLUDING ALL IMAGING, INCLUDING GUIDANCE, AND RADIOLOGICAL SUPERVISION AND INTERPRETATION, WHEN PERFORMED; OPEN	NON-COVERED	CMP201102	PRIOR AUTHORIZATION NOT REQUIRED		
A2002	MIRRAGEN ADVANCED WOUND MATRIX PER SQ CM	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
A2004	XCELLISTEM, 1 MG	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
A2005	MICROLYTE MATRIX, PER SQ CM	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
A2006	NOVOSORB SYNPATH DERMAL MATRIX, PER SQ CM	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
A2007	RESTRATA, PER SQ CM	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
A2008	THERAGENESIS, PER SQ CM	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
A2009	SYMPHONY, PER SQ CM	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
A2010	APIS, PER SQ CM	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
A2033	MYRIAD MORCELLS, 4 MG	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
A2034	FOUNDATION DRS SOLO, PER SQ CM	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
A2035	CORPLEX P OR THERACOR P OR ALLACOR P, PER MG	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4205	MEMBRANE GRAFT OR MEMBRANE WRAP, PER SQ CM	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4208	NOVAFIX, PER SQ CM	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4209	SURGRAFT, PER SQ CM	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4212	ALLOGEN, PER CC	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4214	CELLESTA CORD, PER SQ CM	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4216	ARTACENT CORD, PER SQ CM	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4217	WOUNDFIX, BIOWOUND, WOUNDFIX PLUS, BIOWOUND PLUS, WOUNDFIX XPLUS OR BIOWOUND XPLUS, PER SQ CM	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		

Codes	Code Description	Medical Mutual Commercial	Medical Mutual Commercial Criteria	Medicare Advantage	Medicare Advantage Criteria	Details/Notes
Q4218	SURGICORD, PER SQ CM	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4222	PROGENAMATRIX, PER SQ CM	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4226	MYOWN SKIN, INCLUDES HARVESTING AND PREPARATION PROCEDURES, PER SQ CM	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4234	XCELLERATE, PER SQ CM	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4235	AMNIOREPAIR OR ALTIPLY, PER SQ CM	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4236	CAREPATCH, PER SQ CM	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4237	CRYO-CORD, PER SQ CM	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4239	AMNIO-MAXX OR AMNIO-MAXX LITE, PER SQ CM	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4240	CORECYTE, FOR TOPICAL USE ONLY, PER 0.5 CC	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4245	AMNIOTEXT, PER CC	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4247	AMNIOTEXT PATCH, PER SQ CM	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4248	DERMACYTE AMNIOTIC MEMBRANE ALLOGRAFT, PER SQ CM	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4249	AMNIPLY, FOR TOPICAL USE ONLY, PER SQ CM	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4250	AMNIOAMP-MP, PER SQ CM	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4251	VIM, PER SQ CM	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4252	VENDAJE, PER SQ CM	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4253	ZENITH AMNIOTIC MEMBRANE, PER SQ CM	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4254	NOVAFIX DL, PER SQ CM	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4255	REGUARD, FOR TOPICAL USE ONLY, PER SQ CM	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4354	PALINGEN DUAL-LAYER MEMBRANE, PER SQ CM	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4355	ABIOMEND XPLUS MEMBRANE AND ABIOMEND XPLUS HYDROMEMBRANE, PER SQ CM	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4356	ABIOMEND MEMBRANE AND ABIOMEND HYDROMEMBRANE, PER SQ CM	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4357	XWRAP PLUS, PER SQ CM	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4358	XWRAP DUAL, PER SQ CM	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4359	CHORIPLY, PER SQ CM	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4360	AMCHOPLAST FD, PER SQ CM	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4361	EPIXPRESS, PER SQ CM	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4362	CYGNUS DISK, PER SQ CM	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4363	AMNIO BURGEON MEMBRANE AND HYDROMEMBRANE, PER SQ CM	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4364	AMNIO BURGEON XPLUS MEMBRANE AND XPLUS HYDROMEMBRANE, PER SQ CM	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4365	AMNIO BURGEON DUAL-LAYER MEMBRANE, PER SQ CM	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4366	DUAL LAYER AMNIO BURGEON X-MEMBRANE, PER SQ CM	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4367	AMNIOCORE SL, PER SQ CM	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4368	AMCHOTHICK PER SQ CM	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4369	AMNIOPLAST 3 PER SQ CM	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4370	AEROGUARD PER SQ CM	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4371	NEOGUARD PER SQ CM	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4372	AMCHOPLAST EXCL PER SQ CM	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4373	MEMBRANE WRP LT PER SQ CM	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4375	DUOGRAFT AC PER SQ CM	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4376	DUOGRAFT AA PER SQ CM	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4377	TRIGRAFT FT PER SQ CM	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4378	RENEW FT MATRIX PER SQ CM	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4379	AMNIODEFEND FT MATRIX PER SQ CM	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4380	ADVOGRAFT ONE PER SQ CM	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4381	MATRIX HD ALLOGFT DERMIS PER SQ CM	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4382	ADVOGRAFT DUAL PER SQ CM	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
0402T	COLLAGEN CROSS-LINKING OF CORNEA, INCLUDING REMOVAL OF THE CORNEAL EPITHELIUM, WHEN PERFORMED, AND INTRAOPERATIVE PACHYMETRY, WHEN PERFORMED	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
0446T	CREATION OF SUBCUTANEOUS POCKET WITH INSERTION OF IMPLANTABLE INTERSTITIAL GLUCOSE SENSOR, INCLUDING SYSTEM ACTIVATION AND PATIENT TRAINING	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP200117	PRIOR AUTHORIZATION NOT REQUIRED		
0447T	REMOVAL OF IMPLANTABLE INTERSTITIAL GLUCOSE SENSOR FROM SUBCUTANEOUS POCKET VIA INCISION	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP200117	PRIOR AUTHORIZATION NOT REQUIRED		
0448T	REMOVAL OF IMPLANTABLE INTERSTITIAL GLUCOSE SENSOR WITH CREATION OF SUBCUTANEOUS POCKET AT DIFFERENT ANATOMIC SITE AND INSERTION OF NEW IMPLANTABLE SENSOR, INCLUDING SYSTEM ACTIVATION	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP200117	PRIOR AUTHORIZATION NOT REQUIRED		

Codes	Code Description	Medical Mutual Commercial	Medical Mutual Commercial Criteria	Medicare Advantage	Medicare Advantage Criteria	Details/Notes
0587T	PERCUTANEOUS IMPLANTATION OR REPLACEMENT OF INTEGRATED SINGLE DEVICE NEUROSTIMULATION SYSTEM FOR BLADDER DYSFUNCTION INCLUDING ELECTRODE ARRAY AND RECEIVER OR PULSE GENERATOR, INCLUDING ANALYSIS, PROGRAMMING, AND IMAGING GUIDANCE WHEN PERFORMED, POSTERIOR TIBIAL NERVE	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0588T	REVISION OR REMOVAL OF INTEGRATED SINGLE DEVICE NEUROSTIMULATION SYSTEM INCLUDING ELECTRODE ARRAY AND RECEIVER OR PULSE GENERATOR, INCLUDING ANALYSIS, PROGRAMMING, AND IMAGING GUIDANCE WHEN PERFORMED, POSTERIOR TIBIAL NERVE	NON-COVERED	CMP202406	NON-COVERED	CMP202406	
0790T	REVISION (EG, AUGMENTATION, DIVISION OF TETHER), REPLACEMENT, OR REMOVAL OF THORACOLUMBAR OR LUMBAR VERTEBRAL BODY TETHERING, INCLUDING THORACOSCOPY, WHEN PERFORMED	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP202013	PRIOR AUTHORIZATION NOT REQUIRED		
62380	ENDOSCOPIC DECOMPRESSION OF SPINAL CORD, NERVE ROOT(S), INCLUDING LAMINOTOMY, PARTIAL FACETECTOMY, FORAMINOTOMY, DISCECTOMY AND/OR EXCISION OF HERNIATED INTERVERTEBRAL DISC, 1 INTERSPACE, LUMBAR	NON-COVERED	CMP2019-G	NON-COVERED	CMS	
64910	NERVE REPAIR; WITH SYNTHETIC CONDUIT OR VEIN ALLOGRAFT (EG, NERVE TUBE), EACH NERVE	NON-COVERED	CMP2019-F	NON-COVERED	CMS	
93702	BIOIMPEDANCE SPECTROSCOPY (BIS), EXTRACELLULAR FLUID ANALYSIS FOR LYMPHEDEMA ASSESSMENT(S)	NON-COVERED	MCG A-0667 (CMP202406)	NON-COVERED	CMS	
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	NON-COVERED	CMP2019-G	NON-COVERED	CMS	
28446	OPEN OSTEOCHONDRAL AUTOGRAFT, TALUS (INCLUDES OBTAINING GRAFT(S))	NON-COVERED	CMP200613	NON-COVERED	CMS	
28890	EXTRACORPOREAL SHOCK WAVE, HIGH ENERGY, PERFORMED BY A PHYSICIAN OR OTHER QUALIFIED HEALTH CARE PROFESSIONAL, REQUIRING ANESTHESIA OTHER THAN LOCAL, INCLUDING ULTRASOUND GUIDANCE, INVOLVING THE PLANTAR FASCIA	NON-COVERED	CMP200139	NON-COVERED	CMS	
29855	ARTHROSCOPICALLY AIDED TREATMENT OF TIBIAL FRACTURE, PROXIMAL (PLATEAU); UNICONDYLAR, INCLUDES INTERNAL FIXATION, WHEN PERFORMED (INCLUDES ARTHROSCOPY)	NON-COVERED FOR CERTAIN INDICATIONS (see note)	CMP202406	NON-COVERED FOR CERTAIN INDICATIONS (see note)	CMP202406	IE when determined to be Subchondroplasty with AccuFill Bone Substitute Material (BSM)
30117	EXCISION OR DESTRUCTION (EG, LASER), INTRANASAL LESION; INTERNAL APPROACH	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP200509	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP200509	Investigational/Experimental when determined to be for Vivaer Procedure
31660	BRONCHOSCOPY, RIGID OR FLEXIBLE, INCLUDING FLUOROSCOPIC GUIDANCE, WHEN PERFORMED; WITH BRONCHIAL THERMOPLASTY, 1 LOBE	NON-COVERED	MCG A-0634 (CMP202406)	NON-COVERED	CMS	
31661	BRONCHOSCOPY, RIGID OR FLEXIBLE, INCLUDING FLUOROSCOPIC GUIDANCE, WHEN PERFORMED; WITH BRONCHIAL THERMOPLASTY, 2 OR MORE LOBES	NON-COVERED	MCG A-0634 (CMP202406)	NON-COVERED	CMS	
33548	SURG VENTRICULAR RSTRJ PX W/PROSTC PATCH PFRMD	PRIOR AUTHORIZATION NOT REQUIRED	None	NON-COVERED	CMS	
36473	ENDOVENOUS ABLATION THERAPY OF INCOMPETENT VEIN, EXTREMITY, INCLUSIVE OF ALL IMAGING GUIDANCE AND MONITORING, PERCUTANEOUS, MECHANOCHEMICAL; FIRST VEIN TREATED	NON-COVERED	CMP202406	NON-COVERED	CMP202406	
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)	NON-COVERED	MCG A-1025 (CMP202406)	NON-COVERED	CMS	
43210	ESOPHAGOGASTRODUODENOSCOPY, FLEXIBLE, TRANSORAL; WITH ESOPHAGOGASTRIC FUNDOPLASTY, PARTIAL OR COMPLETE, INCLUDES DUODENOSCOPY WHEN PERFORMED	NON-COVERED	CMP200310	NON-COVERED	CMS	
43257	ESOPHAGOGASTRODUODENOSCOPY, FLEXIBLE, TRANSORAL; WITH DELIVERY OF THERMAL ENERGY TO THE MUSCLE OF LOWER ESOPHAGEAL SPHINCTER AND/OR GASTRIC CARDIA, FOR TREATMENT OF GASTROESOPHAGEAL REFLUX DISEASE	NON-COVERED	CMP200310	NON-COVERED	CMS	
43290	ESOPHAGOGASTRODUODENOSCOPY, FLEXIBLE, TRANSORAL; WITH DEPLOYMENT OF INTRAGASTRIC BARIATRIC BALLOON	NON-COVERED	CMP94030	NON-COVERED	CMS	
46707	REPAIR OF ANORECTAL FISTULA WITH PLUG (EG, PORCINE SMALL INTESTINE SUBMUCOSA (SIS))	NON-COVERED	CMP2009-C	NON-COVERED	CMS	
53855	INSERTION OF A TEMPORARY PROSTATIC URETHRAL STENT, INCLUDING URETHRAL MEASUREMENT	NON-COVERED	CMP201913	NON-COVERED	CMS	
64912	NERVE REPAIR; WITH NERVE ALLOGRAFT, EACH NERVE, FIRST STRAND (CABLE)	NON-COVERED	CMP2019-F	NON-COVERED	CMS	

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64913	NERVE REPAIR; WITH NERVE ALLOGRAFT, EACH ADDITIONAL STRAND (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)	NON-COVERED	CMP2019-F	NON-COVERED	CMS	
86343	LEUKOCYTE HISTAMINE RELEASE TEST (LHR)	NON-COVERED	CMP99005	NON-COVERED	CMS	
95803	ACTIGRAPHY TESTING, RECORDING, ANALYSIS, INTERPRETATION, AND REPORT (MINIMUM OF 72 HOURS TO 14 CONSECUTIVE DAYS OF RECORDING)	NON-COVERED	CMP2018-C	NON-COVERED	CMS	
E0761	NON-THERMAL PULSED HIGH FREQUENCY RADIOWAVES, HIGH PEAK POWER ELECTROMAGNETIC ENERGY TREATMENT DEVICE	NON-COVERED	MCG A-0242 (CMP202406)	NON-COVERED	CMS	
G0295	ELECTROMAGNETIC THERAPY, TO ONE OR MORE AREAS, FOR WOUND CARE OTHER THAN DESCRIBED IN G0329 OR FOR OTHER USES	NON-COVERED	MCG A-0242 (CMP202406)	NON-COVERED	CMS	
G0341	PERCUTANEOUS ISLET CELL TRANSPLANT, INCLUDES PORTAL VEIN CATHETERIZATION AND INFUSION	NON-COVERED	CMP201102	NON-COVERED	CMS	
G0342	LAPAROSCOPY FOR ISLET CELL TRANSPLANT, INCLUDES PORTAL VEIN CATHETERIZATION AND INFUSION	NON-COVERED	CMP201102	NON-COVERED	CMS	
G0343	LAPAROTOMY FOR ISLET CELL TRANSPLANT, INCLUDES PORTAL VEIN CATHETERIZATION AND INFUSION	NON-COVERED	CMP201102	NON-COVERED	CMS	
Q4112	CYMETRA, INJECTABLE, 1 CC	NON-COVERED	CMP200233	NON-COVERED	CMS	
Q4113	GRAFTJACKET XPRESS, INJECTABLE, 1 CC	NON-COVERED	CMP200233	NON-COVERED	CMS	
Q4114	INTEGRA FLOWABLE WOUND MATRIX, INJECTABLE, 1 CC	NON-COVERED	CMP200233	NON-COVERED	CMS	
Q4125	ARTHROFLEX, PER SQUARE CENTIMETER	NON-COVERED	CMP200233	NON-COVERED	CMS	
Q4130	STRATTICE TM, PER SQUARE CENTIMETER	NON-COVERED	CMP200233	NON-COVERED	CMS	
Q4138	BIODFENCE DRYFLEX, PER SQUARE CENTIMETER	NON-COVERED	CMP200233	NON-COVERED	CMS	
Q4139	AMNIOMATRIX OR BIODMATRIX, INJECTABLE, 1 CC	NON-COVERED	CMP200233	NON-COVERED	CMS	
Q4142	XCM BIOLOGIC TISSUE MATRIX, PER SQUARE CENTIMETER	NON-COVERED	CMP200233	NON-COVERED	CMS	
Q4143	REPRIZA, PER SQUARE CENTIMETER	NON-COVERED	CMP200233	NON-COVERED	CMS	
Q4145	EPIFIX, INJECTABLE, 1 MG	NON-COVERED	CMP200233	NON-COVERED	CMS	
Q4149	EXCELLAGEN, 0.1 CC	NON-COVERED	CMP200233	NON-COVERED	CMS	
Q4150	ALLOWRAP DS OR DRY, PER SQUARE CENTIMETER	NON-COVERED	CMP200233	NON-COVERED	CMS	
Q4155	NEOXFLO OR CLARIXFLO, 1 MG	NON-COVERED	CMP200233	NON-COVERED	CMS	
Q4171	INTERFYL, 1 MG	NON-COVERED	CMP200233	NON-COVERED	CMS	
Q4174	PALINGEN OR PROMATRX, 0.36 MG PER 0.25 CC	NON-COVERED	CMP200233	NON-COVERED	CMS	
Q4177	FLOWERAMNIOFLO, 0.1 CC	NON-COVERED	CMP200233	NON-COVERED	CMS	
Q4179	FLOWERDERM, PER SQUARE CENTIMETER	NON-COVERED	CMP200233	NON-COVERED	CMS	
Q4183	SURGIGRAFT, PER SQUARE CENTIMETER	NON-COVERED	CMP200233	NON-COVERED	CMS	
Q4184	CELLESTA OR CELLESTA DUO, PER SQUARE CENTIMETER	NON-COVERED	CMP200233	NON-COVERED	CMS	
Q4189	ARTACENT AC, 1 MG	NON-COVERED	CMP200233	NON-COVERED	CMS	
Q4190	ARTACENT AC, PER SQUARE CENTIMETER	NON-COVERED	CMP200233	NON-COVERED	CMS	
Q4191	RESTORIGIN, PER SQUARE CENTIMETER	NON-COVERED	CMP200233	NON-COVERED	CMS	
Q4192	RESTORIGIN, 1 CC	NON-COVERED	CMP200233	NON-COVERED	CMS	
Q4193	COLL-E-DERM, PER SQUARE CENTIMETER	NON-COVERED	CMP200233	NON-COVERED	CMS	
Q4194	NOVACHOR, PER SQUARE CENTIMETER	NON-COVERED	CMP200233	NON-COVERED	CMS	
Q4199	CYGNUS MATRIX, PER SQUARE CENTIMETER	NON-COVERED	CMP200233	NON-COVERED	CMS	
S9090	Vertebral axial decompression, per session	NON-COVERED	CMP2005-J	NON-COVERED	CMS	
0217T	NJX DX/THER PARAVER FCT JT W/US LUMB/SAC LVL 2	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0218T	NJX PARAVERTBRL FCT JT W/US LUMB/SAC 3RD&> LVL	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0263T	AUTO BONE MARRW CELL RX COMPLT BONE MARRW HARVST	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0264T	AUTO BONE MARRW CELL RX COMP W/O BONE MAR HARVST	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0332T	MYOCRD SYMP INNERVAJ IMG PLNR QUAL&QUANT W/SPECT	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0347T	PLACE INTERSTITIAL DEVICE(S) IN BONE FOR RSA	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0640T	NCNTC NR IFR SPECTRSC OTH/THN PAD 1ST ANTMC SITE	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0101T	EXTRACORPOREAL SHOCK WAVE INVOLVING MUSCULOSKELETAL SYSTEM, NOT OTHERWISE SPECIFIED	NON-COVERED	CMP200139, CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0102T	EXTRACORPOREAL SHOCK WAVE PERFORMED BY A PHYSICIAN, REQUIRING ANESTHESIA OTHER THAN LOCAL, AND INVOLVING THE LATERAL HUMERAL EPICONDYLE	NON-COVERED	CMP200139, CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0397T	ERCP WITH OPTICAL ENDOMICROSCOPY ADD ON	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0403T	DIABETES PREVENTION PROG STANDARDIZED CURRICULUM	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0419T	DSTRJ NEUROFIBROMA XTNSV FACE HEAD NECK >50	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0420T	DSTRJ NEUROFIBROMA XTNSV TRNK EXTREMITIES >100	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0422T	TACTILE BREAST IMG COMPUTER-AIDED SENSORS UNI/BI	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0426T	INSJ/RPLC NSTIM SYSTEM SLEEP APNEA STIMJ LEAD	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0437T	IMPLTJ NONBIOL/SYNTH IMPLT FASC RNFCMT ABDL WALL	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		

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0439T	MYOCARDIAL PERFUSION ECHO ISCHM/VIABILITY ASSMT	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0440T	ABLTJ PERC CRYOABLTJ IMG GDN UXTR/PERPH NERVE	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0441T	ABLTJ PERC CRYOABLTJ IMG GDN LXTR/PERPH NERVE	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0442T	ABLTJ PERC CRYOABLTJ IMG GDN NRV PLEX/TRNCL NRV	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0443T	R-T SPCTRL ALYS PRST8 TISS FLUORESCENC SPCTRSCPY	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0444T	INITIAL PLACEMENT OF A DRUG-ELUTING OCULAR INSERT UNDER ONE OR MORE EYELIDS, INCLUDING FITTING, TRAINING, AND INSERTION, UNILATERAL OR BILATERAL	NON-COVERED	CMP201721, CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0445T	SUBSEQUENT PLACEMENT OF A DRUG-ELUTING OCULAR INSERT UNDER ONE OR MORE EYELIDS, INCLUDING RE-TRAINING, AND REMOVAL OF EXISTING INSERT, UNILATERAL OR BILATERAL	NON-COVERED	CMP201721, CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0488T	DIABETES PREV ONLINE/ELECTRONIC PRGRM PR 30 DAYS	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0593T	HEALTH & WELL-BEING COACHING FACE TO FACE GROUP	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0594T	OSTEOT HUM INSJ XTRNL CTRLD IMED LNGTH DEVICE	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0596T	TEMP FEMALE INTRAURETHRAL VALVE-PUMP 1ST INSJ	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0597T	TEMP FEMALE INTRAURETHRAL VALVE-PUMP REPLACEMENT	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0598T	NONCONTACT R-T FLUOR WND IMG 1ST ANATOMIC SITE	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0599T	NONCONTACT R-T FLUOR WND IMG EA ADDL ANTMC SITE	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0600T	ABLATION, IRREVERSIBLE ELECTROPORATION; 1 OR MORE TUMORS PER ORGAN, INCLUDING IMAGING GUIDANCE, WHEN PERFORMED, PERCUTANEOUS	NON-COVERED	CMP202015, CMP202406	NON-COVERED	CMP202015, CMP202406	
0601T	ABLATION, IRREVERSIBLE ELECTROPORATION; 1 OR MORE TUMORS PER ORGAN, INCLUDING FLUOROSCOPIC AND ULTRASOUND GUIDANCE, WHEN PERFORMED, OPEN	NON-COVERED	CMP202015, CMP202406	NON-COVERED	CMP202015, CMP202406	
0602T	TRANSDERMAL GFR MEAS SNR PLMT&1 DOS PYRAZINE AGT	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0603T	TDRM GFR MNTR SNR PLMT&>1 DOS PYRAZINE EA 24 HRS	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0607T	REM MNTR XTRNL CONT PULM FLU MNTR SYS SETUP	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0608T	REM MNTR XTRNL CONT PULM FLU MNTR SYS ALYS DATA	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0609T	MRS DISCOGENIC PAIN ACQUISJ SINGLE VOXEL DATA	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0610T	MRS DISCOGENIC PAIN TRANSMIS BMRK DATA SW ALYS	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0042T	CEREBRAL PERFUSION ANALYS CT W/BLOOD FLOW&VOLUME	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0071T	FOCUSED ULTRASOUND ABLATION OF UTERINE LEIOMYOMATA, INCLUDING MR GUIDANCE; TOTAL LEIOMYOMATA VOLUME LESS THAN 200 CC OF TISSUE	NON-COVERED	MCG A-0289 (CMP202406)	PRIOR AUTHORIZATION NOT REQUIRED		
0072T	FCSD US ABLTJ UTERINE LEIOMYOMAT >= 200 CC TISS	NON-COVERED	MCG A-0289 (CMP202406)	PRIOR AUTHORIZATION NOT REQUIRED		
0100T	PLMT SCJNCL RTA PROSTH&PLS&IMPLTJ INTRA-OC RTA	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0106T	QUANT SENSORY TEST&INTERPJ/XTR W/TOUCH STIMULI	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0107T	QUANT SENSORY TEST&INTERPJ/XTR W/VIBRJ STIMULI	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0108T	QUANT SENSORY TEST&INTERPJ/XTR W/COOL STIMULI	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0109T	QUANT SENAORY TEST&INTERPJ/XTR W/HT-PN STIMULI	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0110T	QUANT SENSORY TEST&INTERPJ/XTR OTHER STIMULI	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0184T	RECTAL TUMOR EXCISION TRANSANAL ENDOSCOPIC	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0198T	MEAS OCULAR BLOOD FLOW REPEAT IO PRES SAMP W/I&R	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0200T	PERQ SAC AGMNTJ UNI W/WO BALO/MCHNL DEV 1/> NDL	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0201T	PERQ SAC AGMNTJ BI W/WO BALO/MCHNL DEV 2/> NDLS	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0202T	POST VERT ARTHRPLSTY W/WO BONE CEMENT 1 LUMB LVL	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0207T	EVAC MEIBOMIAN GLNDS AUTO HT& INTMT PRESS UNI	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0208T	PURE TONE AUDIOMETRY AUTOMATED AIR ONLY	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0209T	PURE TONE AUDIOMETRY AUTOMATED AIR & BONE	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0210T	SPEECH AUDIOMETRY THRESHOLD AUTOMATED	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0211T	SPEECH AUDIOM THRESHLD AUTO W/SPEECH RECOGNITION	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0212T	COMPRE AUDIOM THRESHOLD EVAL & SPEECH RECOG	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0213T	NJX DX/THER PARAVER FCT JT W/US CER/THOR 1 LVL	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0214T	NJX DX/THER PARAVER FCT JT W/US CER/THOR 2ND LVL	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0215T	NJX PARAVERTBRL FACET JT W/US CER/THOR 3RD&> LVL	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0216T	NJX DX/THER PARAVER FCT JT W/US LUMB/SAC 1 LVL	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0219T	PLMT POST FACET IMPLANT UNI/BI W/IMG & GRFT CERV	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0220T	PLMT POST FACET IMPLT UNI/BI W/IMG & GRFT THOR	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0221T	PLMT POST FACET IMPLT UNI/BI W/IMG & GRFT LUMB	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0222T	PLACE POSTERIOR INTRAFACET IMPLANT ADDL SEGMENT	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0253T	INSERTION OF ANTERIOR SEGMENT AQUEOUS DRAINAGE DEVICE, WITHOUT EXTRAOCULAR RESERVOIR, INTERNAL APPROACH, INTO THE SUPRACHOROIDAL SPACE	NON-COVERED	CMP201721, CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		

Codes	Code Description	Medical Mutual Commercial	Medical Mutual Commercial Criteria	Medicare Advantage	Medicare Advantage Criteria	Details/Notes
0265T	BONE MAR HARVST ONLY FOR INTMUSC AUTOLO CELL RX	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT 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 (EG, FLUOROSCOPIC, CT), SINGLE OR MULTIPLE LEVELS, UNILATERAL OR BILATERAL; CERVICAL OR THORACIC	NON-COVERED	CMP2019-G, CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0275T	PERCUTANEOUS LAMINOTOMY/LAMINECTOMY (INTERLAMINAR APPROACH) FOR DECOMPRESSION OF NEURAL ELEMENTS, (WITH OR WITHOUT LIGAMENTOUS RESECTION, DISCECTOMY, FACETECTOMY AND/OR FORAMINOTOMY), ANY METHOD, UNDER INDIRECT IMAGE GUIDANCE (EG, FLUOROSCOPIC, CT), SINGLE OR MULTIPLE LEVELS, UNILATERAL OR BILATERAL; LUMBAR	NON-COVERED	CMP2019-G, CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0278T	TRANSCUTANEOUS ELECTRICAL MODULATION PAIN REPROCESSING (EG, SCRAMBLER THERAPY), EACH TREATMENT SESSION (INCLUDES PLACEMENT OF ELECTRODES)	NON-COVERED	CMP201004, CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0308T	INSERTION OF OCULAR TELESCOPE PROSTHESIS INCLUDING REMOVAL OF CRYSTALLINE LENS OR INTRAOCULAR LENS PROSTHESIS	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0329T	MNTR INTRAOCULAR PRESS 24HRS/> UNI/BI W/INTERP	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0330T	TEAR FILM IMAGING UNILATERAL OR BILATERAL W/I&R	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0331T	MYOCRD SYMPATHETIC INNERVAJ IMG PLNR QUAL&QUANT	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0333T	VISUAL EVOKED POTENTIAL ACUITY SCREENING AUTO	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0335T	INSERTION OF SINUS TARSI IMPLANT	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0338T	TRANSCATHETER RENAL SYMPATH DENERVATION UNILAT	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0339T	TRANSCATHETER RENAL SYMPATH DENERVATION BILAT	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0342T	THERAPEUTIC APHERESIS W/SELECTIVE HDL DELIP	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0348T	RADIOSTEREOMETRIC ANALYSIS SPINE EXAM	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0349T	RADIOSTEREOMETRIC ANALYSIS UPPER EXTREMITY EXAM	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0350T	RADIOSTEREOMETRIC ANALYSIS LOWER EXTREMITY EXAM	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0351T	INTRAOP OCT BREAST OR AXILL NODE EACH SPECIMEN	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0352T	OCT BREAST OR AXILL NODE SPECIMEN I&R	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0353T	OCT OF BREAST SURG CAVITY REAL TIME INTRAOP	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0354T	OCT BREAST SURG CAVITY REAL TIME/REFERRED I&R	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0358T	BIA WHOLE BODY COMPOSITION ASSESSMENT W/I&R	NON-COVERED	MCG A-0667 (CMP202406)	PRIOR AUTHORIZATION NOT REQUIRED		
0362T	BEHAVIOR ID SUPPORT ASSMT EA 15 MIN TECH TIME	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0373T	ADAPT BHV TX PRTCL MODIFICAJ EA 15 MIN TECH TIME	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0378T	VISUAL FIELD ASSESSMENT PHYS REVIEW AND REPORT	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0379T	VISUAL FIELD ASSESSMENT TECH SUPPORT W/INSTRUCT	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0464T	VISUAL EP TESTING FOR GLAUCOMA W/INTERPJ & REPRT	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0469T	RTA POLARIZE SCAN OC SCR W/ONSITE AUTO RSLT BI	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0472T	DEV INTERR PRGRMG IO RTA ELTRD RA W/ADJ & REPRT	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0473T	DEV INTERR REPRGRMG IO RTA ELTRD RA W/REPRT	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0474T	INSERTION OF ANTERIOR SEGMENT AQUEOUS DRAINAGE DEVICE, WITH CREATION OF INTRAOCULAR RESERVOIR, INTERNAL APPROACH, INTO THE SUPRACILIARY SPACE	NON-COVERED	CMP201721, CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0479T	FRACTIONAL ABL LSR FENESTRATION FIRST 100 SQCM	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0480T	FRACTIONAL ABL LSR FENESTRATION EA ADDL 100 SQCM	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0481T	NJX AUTOL WBC CONCENTR INC IMG GDN HRV & PREP	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0483T	TRANSCATHETER MITRAL VALVE IMPLANTATION/REPLACEMENT (TMVI) WITH PROSTHETIC VALVE; PERCUTANEOUS APPROACH, INCLUDING TRANSSEPTAL PUNCTURE, WHEN PERFORMED	NON-COVERED	CMP202012, CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0484T	TRANSCATHETER MITRAL VALVE IMPLANTATION/REPLACEMENT (TMVI) WITH PROSTHETIC VALVE; TRANSTHORACIC EXPOSURE (EG, THORACOTOMY, TRANSAPICAL)	NON-COVERED	CMP202012, CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0485T	OCT MIDDLE EAR WITH I&R UNILATERAL	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0486T	OCT MIDDLE EAR WITH I&R BILATERAL	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0489T	AUTOL REGN CELL TX SCLERODERMA HANDS	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0490T	AUTOL REGN CELL TX SCLDR MLT INJ 1/> HANDS	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0494T	PREP & CANNULJ CDVR DON LNG ORGN PRFUJ SYS	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0495T	INIT & MNTR CDVR DON LNG ORGN PRFUJ SYS 1ST 2 HR	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0496T	MNTR CDVR DON LNG ORGN PRFUJ SYS EA ADDL HR	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0506T	MAC PGMT OPTICAL DNS MEAS HFP UNI/BI W/I&R	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		

Codes	Code Description	Medical Mutual Commercial	Medical Mutual Commercial Criteria	Medicare Advantage	Medicare Advantage Criteria	Details/Notes
0509T	PATTERN ELECTRORETINOGRAPHY W/I&R	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0510T	REMOVAL OF SINUS TARSI IMPLANT	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0511T	REMOVAL AND REINSERTION OF SINUS TARSI IMPLANT	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0512T	EXTRACORPOREAL SHOCK WAVE FOR INTEGUMENTARY WOUND HEALING, INCLUDING TOPICAL APPLICATION AND DRESSING CARE; INITIAL WOUND	NON-COVERED	CMP200139, CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0513T	EXTRACORPOREAL SHOCK WAVE FOR INTEGUMENTARY WOUND HEALING, INCLUDING TOPICAL APPLICATION AND DRESSING CARE; EACH ADDITIONAL WOUND (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)	NON-COVERED	CMP200139, CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0515T	INSERTION WRLS CAR STIMULATOR LV PACG COMPL SYS	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0516T	INSERTION WRLS CAR STIMULATOR LV PACG ELTRD ONLY	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0517T	INSERTION WRLS CAR STIMULATOR LV PACG BTH COMPNT	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0518T	REMOVAL PG WCS LV PACG BATTERY COMPONENT ONLY	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0519T	REMOVAL&RPLCMT PG WCS LV PACG BOTH COMPONENTS	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0520T	RMVL&RPLCMT PG WCS LV PACG BATTERY COMPNT ONLY	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0521T	INTERROG DEV EVAL WRLS CAR STIMULATOR IN PERSON	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0522T	PRGRMG DEVICE EVAL WRLS CAR STIMULATOR IN PERSON	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0523T	INTRAPROCEDURAL CORONARY FFP W/3D FUNCJL MAPPING	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0525T	INSERTION/REPLACEMENT COMPLETE IIMS	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0526T	INSERTION/REPLACEMENT IIMS ELECTRODE ONLY	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0527T	INSERTION/REPLACEMENT IIMS IMPLANTABLE MNTR ONLY	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0530T	REMOVAL COMPLETE IIMS INCL IMG S&I	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0531T	REMOVAL IIMS ELECTRODE ONLY INCL IMG S&I	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0532T	REMOVAL IIMS IMPLANTABLE MNTR ONLY INCL IMG S&I	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0543T	TRANSAPICAL MV RPR W/TTE PLMT ARTIF CHORDAE TEND	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0544T	TCAT MV ANN RCNSTJ W/IMPL ADJST ANN RCNSTJ DEV	NON-COVERED	CMP202012, CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0545T	TCAT TV ANN RCNSTJ W/IMPL ADJST ANN RCNSTJ DEV	NON-COVERED	CMP202012, CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0547T	BONE-MATERIAL QUALITY TESTING BY MICROINDENTATION(S) OF THE TIBIA(S), WITH RESULTS REPORTED AS A SCORE	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0553T	PERQ TCAT PLMT ILIAC ARVEN ANASTOMOSIS IMPLANT	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0555T	BONE STRENGTH AND FRACTURE RISK USING FINITE ELEMENT ANALYSIS OF FUNCTIONAL DATA, AND BONE-MINERAL DENSITY, UTILIZING DATA FROM A COMPUTED TOMOGRAPHY SCAN; RETRIEVAL AND TRANSMISSION OF THE SCAN DATA	NON-COVERED	CMP94022, CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0558T	CT SCAN FOR PURPOSE BIOMECHANICAL CT ANALYSIS	NON-COVERED	CMP94022, CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0559T	ANATOMIC MODEL 3D PRINTED 1ST COMPNT ANTMC STRUX	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0560T	ANATOMIC MODEL 3D PRINTED EA ADDL COMPONENT	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0561T	ANATOMIC GUIDE 3D PRINTED 1ST ANATOMIC GUIDE	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0562T	ANATOMIC GUIDE 3D PRINTED EA ADDL ANATOMIC GUIDE	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0563T	EVACUATION MEIBOMIAN GLANDS USING HEAT BILATERAL	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0565T	AUTOL CELL IMPLT ADPS TISS HRVG CELL IMPLT CRTJ	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0566T	AUTOL CELL IMPLT ADPS TISS NJX IMPLT KNEE UNI	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0569T	TTVR PERCUTANEOUS APPROACH INITIAL PROSTHESIS	NON-COVERED	CMP202012, CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0570T	TTVR PERCUTANEOUS APPROACH EACH ADDL PROSTHESIS	NON-COVERED	CMP202012, CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0573T	RMVL SUBSTERNAL IMPLANTABLE DEFIBRILLATOR ELTRD	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0575T	PROGRAMMING DEV EVAL ICDS W/SS ELTRD IN PERSON	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0576T	INTERROGATION DEV EVAL ICDS W/SS ELTRD IN PERSON	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0579T	REM INTERROG DEV EVAL SS LD ICDS < 90D TECH	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0580T	RMVL SUBSTERNAL IMPLTBL DFB PULSE GENERATOR ONLY	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0581T	ABLATION MAL BRST TUMOR PERQ CRTX UNILATERAL	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0583T	TYMPANOSTOMY AUTOMATED TUBE DELIVERY SYSTEM	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0584T	ISLET CELL TRANSPLANT, INCLUDES PORTAL VEIN CATHETERIZATION AND INFUSION, INCLUDING ALL IMAGING, INCLUDING GUIDANCE, AND RADIOLOGICAL SUPERVISION AND INTERPRETATION, WHEN PERFORMED; PERCUTANEOUS	NON-COVERED	CMP201102, CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0585T	ISLET CELL TRANSPLANT, INCLUDES PORTAL VEIN CATHETERIZATION AND INFUSION, INCLUDING ALL IMAGING, INCLUDING GUIDANCE, AND RADIOLOGICAL SUPERVISION AND INTERPRETATION, WHEN PERFORMED; LAPAROSCOPIC	NON-COVERED	CMP201102, CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0589T	ELEC ALYS SMPL PRGRMG IINS BLDR DYSF PTN 1-3	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0590T	ELEC ALYS CPLX PRGRMG IINS BLDR DYSF PTN 4+	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0591T	HEALTH & WELL-BEING COACHING F2F INDIV 1ST ASSMT	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0592T	HEALTH & WELL-BEING COACHING F2F INDIV F-UP SESS	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		

Codes	Code Description	Medical Mutual Commercial	Medical Mutual Commercial Criteria	Medicare Advantage	Medicare Advantage Criteria	Details/Notes
0611T	MRS DISCOGENIC PAIN ALGORTHMIC ALYS BMRK DATA	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0612T	MRS DISCOGENIC PAIN INTERPRETATION AND REPORT	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0613T	PERQ TCAT IMPLTJ INTRATRL SEPTAL SHUNT DEVICE	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0614T	RMVL&RPLCMT SUBSTERNAL IMPLTBL DEFIBRILLATOR PG	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0619T	CYSTO W/TRURL ANT PRST8 COMMISSUROTOMY & RX DLVR	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0620T	ENDOVASCULAR VENOUS ARTERIALIZATION TIBL/PRNL VN	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0621T	TRABECULOSTOMY AB INTERNO BY LASER;	NON-COVERED	CMP201721, CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0622T	TRABECULOSTOMY AB INTERNO BY LASER; WITH USE OF OPHTHALMIC ENDOSCOPE	NON-COVERED	CMP201721, CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0623T	AUTO QUAN&CHARAC CORONARY ATHEROSCLEROTIC PLAQUE	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0624T	AUTO QUAN&CHARAC CORONARY PLAQ DATA PREP&TRNSMIS	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0625T	AUTO QUAN&CHARAC CORONARY PLAQ COMPUTERIZED ALYS	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0626T	AUTO QUAN&CHARAC CORONARY PLAQ REV CPTR ALYS I&R	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0627T	PERQ NJX ALGC CELL &/PRDCT UNI/BI FLUOR LMBR 1ST	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0628T	PERQ NJX ALGC CELL &/PRDCT UNI/BI FLUOR LMBR EA	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0629T	PERQ NJX ALGC CELL&/PRDCT UNI/BI CT LMBR 1ST	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0630T	PERQ NJX ALGC CELL&/PRDCT UNI/BI CT LMBR EA	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0631T	TC VISIBLE LIGHT HYPERSPECTRAL IMG MEAS PER XTR	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0632T	PERQ TCAT US ABLATION NERVES INNERVATING P-ART	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0633T	CT BREAST W/3D RENDERING UNI WITHOUT CONTRAST	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0634T	CT BREAST W/3D RENDERING UNI WITH CONTRAST	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0635T	CT BRST W/3D RENDERING UNI WO CNTRST FLWD CNTRST	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0636T	CT BREAST W/3D RENDERING BI WITHOUT CONTRAST	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0637T	CT BREAST W/3D RENDERING BI WITH CONTRAST	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0638T	CT BRST W/3D RENDERING BI WO CNTRST FLWD CNTRST	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0639T	WIRELESS SKIN SNR THERMAL ANISOTROPY MEAS&ASSMT	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0643T	TRANSCATHETER L VENTR RESTORATION DEVICE IMPLTJ	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0644T	TRANSCATHETER REMOVAL OR DEBULKING OF INTRACARDIAC MASS (EG, VEGETATIONS, THROMBUS) VIA SUCTION (EG, VACUUM, ASPIRATION) DEVICE, PERCUTANEOUS APPROACH, WITH INTRAOPERATIVE REINFUSION OF ASPIRATED BLOOD, INCLUDING IMAGING GUIDANCE, WHEN PERFORMED	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0645T	TRANSCATHETER IMPLANTATION OF CORONARY SINUS REDUCTION DEVICE INCLUDING VASCULAR ACCESS AND CLOSURE, RIGHT HEART CATHETERIZATION, VENOUS ANGIOGRAPHY, CORONARY SINUS ANGIOGRAPHY, IMAGING GUIDANCE, AND SUPERVISION AND INTERPRETATION, WHEN PERFORMED	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0646T	TTVI/RPLCMT PROSTC VLV PERQ W/R HRT CATH&ANGRPH	NON-COVERED	CMP202012, CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0647T	INSJ GASTROSTOMY TUBE PERQ W/MAGNETIC GASTROPEXY	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0648T	QUAN MR ALYS TISS COMPJ W/O MRI SAME SESS 1ORGN	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0649T	QUAN MR ALYS TISS COMPOSITION W/MRI 1ORGN	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0650T	PRGRMG DEV EVAL SCRMS PHYS/QHP REMOTE	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0652T	EGD FLEXIBLE TRANSNASAL DX W/COLLJ SPEC BR/WA	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0653T	EGD FLEXIBLE TRANSNASAL W/BIOPSY SINGLE/MULTIPLE	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0654T	EGD FLEXIBLE TRANSNASAL W/INSJ INTRAL TUBE/CATH	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0655T	TRANSPERINEAL FOCAL LASER ABLTJ MAL PRST8 TISS	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0658T	ELECTRICAL IMPEDENCE SPECTROSCOPY 1+SKIN LESIONS	NON-COVERED	CMP200903, CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0659T	TCAT INTRA-C NFS SUPERSAT O2 W/PERQ C REVSC AMI	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0660T	IMPLANTATION OF ANTERIOR SEGMENT INTRAOCULAR NONBIODEGRADABLE DRUG-ELUTING SYSTEM, INTERNAL APPROACH	NON-COVERED	CMP201721, CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0661T	REMOVAL AND REIMPLANTATION OF ANTERIOR SEGMENT INTRAOCULAR NONBIODEGRADABLE DRUG-ELUTING IMPLANT	NON-COVERED	CMP201721, CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0662T	SCALP COOLING 1ST MEASUREMENT & CAP CALIBRATION	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0663T	SCALP COOLING PLACEMENT MNTR & REMOVAL OF DEVICE	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0664T	DONOR HYSTERECTOMY (INCLUDING COLD PRESERVATION); OPEN, FROM CADAVER DONOR	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0665T	DONOR HYSTERECTOMY (INCLUDING COLD PRESERVATION); OPEN FROM LIVING DONOR	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0666T	DONOR HYSTERECTOMY (INCLUDING COLD PRESERVATION); LAPAROSCOPIC OR ROBOTIC, FROM LIVING DONOR	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0667T	DONOR HYSTERECTOMY (INCLUDING COLD PRESERVATION); RECIPIENT UTERUS ALLOGRAFT TRANSPLANTATION FROM CADAVER OR LIVING DONOR	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0668T	BACKBENCH PREP CDVR/LIV DONOR UTERINE ALLOGRAFT	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		

Codes	Code Description	Medical Mutual Commercial	Medical Mutual Commercial Criteria	Medicare Advantage	Medicare Advantage Criteria	Details/Notes
0669T	BCKBNCH RCNSTJ CDVR/LIV DON UTER ALGRFT VEN ANST	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0670T	BCKBNCH RCNSTJ CDVR/LIV DON UTER ALGRFT ART ANST	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0672T	NDOVAG CRYG COOLD RF REMDL TISS FML BLDR NCK&URT	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0673T	ABLATION B9 THYROID NODULE PERQ LASER W/IMG GDN	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0674T	LAPS INSJ NEW/RPLCMT PERM ISDSS AGMNTJ CAR FUNCJ	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0675T	LAPS INSJ NEW/RPLCMT LEAD PERM ISDSS 1ST LEAD	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0676T	LAPS INSJ NEW/RPLCMT LEAD PERM ISDSS EA ADL LEAD	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0677T	LAPS REPOS LEAD PERM ISDSS 1ST REPOSITIONED LEAD	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0678T	LAPS REPOS LEAD PERM ISDSS EA ADDL REPOS LEAD	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0679T	LAPAROSCOPIC REMOVAL LEAD PERM ISDSS	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0680T	INSJ/RPLCMT PULSE GENERATOR ONLY ISDSS	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0681T	RELOCATION PULSE GENERATOR ONLY ISDSS	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0682T	REMOVAL PULSE GENERATOR ONLY ISDSS	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0683T	PROGRAMMING DEVICE EVALUATION IN PERSON ISDSS	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0684T	PERIPROCEDURAL DEVICE EVALUATION IN PERSON ISDSS	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0685T	INTERROGATION DEVICE EVALUATION IN PERSON ISDSS	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0686T	HISTOTRIPSY MAL HEPATOCELLULAR TISS W/IMG GDN	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0687T	TX AMBLYOPIA DEV SUPLY EDUCATIONAL SETUP 1ST SES	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0688T	TX AMBLYOPIA ASSMT PERF PHYS/QHP W/REPORT CAL MO	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0689T	QUAN US TISS CHARAC I&R W/O DX US SAME ANAT	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0690T	QUANTITATIVE US TISS CHARAC I&R W/DX US SM ANAT	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0691T	AUTO ALYS XST CT VRT FX ASMT B1 DNS DATA PRP I&R	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0692T	THERAPEUTIC ULTRAFILTRATION	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0693T	COMPRE FUL BDY CPTR MRKRLS 3D KNMTC&KIN MTN ALYS	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0694T	3D VOLUMETRIC IMG&RCNSTJ BRST/AX LYMPH NODE TISS	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0695T	BDY SURF ACTIVATION MAPG PM/CVDFB LEADS TM IMPLT	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0696T	BDY SURF ACTIVATION MAPG PM/CVDFB LEADS TM F/UP	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0697T	QUAN MR ALYS TIS COMPJ WO MRI SAME SESS MLT ORGN	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0698T	QUAN MR ALYS TISS COMPOSITION W/MRI MLT ORGANS	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0699T	INJECTION POSTERIOR CHAMBER EYE MEDICATION	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0700T	MOLECULAR FLUOR IMAGING SUSPICIOUS NEVUS 1ST LES	NON-COVERED	CMP200903, CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0701T	MOLECULAR FLUOR IMAGING SUSPICIOUS NEVUS EA ADDL	NON-COVERED	CMP200903, CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0702T	Remote therapeutic monitoring of a standardized online digital cognitive behavioral therapy program ordered by a physician or other qualified health care professional; supply and technical support, per 30 days	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0704T	REM TX AMBLYOPIA DEV SUPPLY 1ST SETUP&PT EDUCAJ	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0705T	REM TX AMBLYOPIA TCH SPRT MIN 18 TRAING HR EA 30	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0706T	REM TX AMBLYOPIA I&R PHYS/QHP PER CALENDAR MONTH	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0707T	INJECTION(S), BONE-SUBSTITUTE MATERIAL (EG, CALCIUM PHOSPHATE) INTO SUBCHONDRAL BONE DEFECT (IE, BONE MARROW LESION, BONE BRUISE, STRESS INJURY, MICROTRABECULAR FRACTURE), INCLUDING IMAGING GUIDANCE AND ARTHROSCOPIC ASSISTANCE FOR JOINT VISUALIZATION	NON-COVERED	CMP2019-B, CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0708T	INTRADERMAL CANCER IMMNTX PREP & 1ST INJECTION	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0709T	INTRADERMAL CANCER IMMNTX EACH ADDL INJECTION	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0710T	N-INVAS ARTL PLAQ ALYS DATA PRP QUAN REVIEW I&R	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0711T	N-INVAS ARTL PLAQ ALYS DATA PREP & TRANSMISSION	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0712T	N-INVAS ARTL PLAQ ALYS QUAN STRUX&COMPOS VSL WAL	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0713T	N-INVAS ARTL PLAQ ALYS DATA REVIEW I&R	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0714T	TPLA B9 PROSTATIC HYPERPLASIA PRST8 VOL<50 ML	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0716T	CARDIAC ACOUS WAVFRM REC AUTO ALYS CAD RSK SCORE	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0717T	ADRC THER PRTL THICKNESS RC TEAR	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0718T	ADRC THER PRTL THICKNESS RC TEAR NJX TENDON UNI	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0719T	PST VERTEBRAL JOINT RPLCMT LUMBAR SPI SINGLE SGM	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0720T	PERCUTANEOUS ELECTRICAL NERVE FIELD STIMULATION, CRANIAL NERVES, WITHOUT IMPLANTATION	NON-COVERED	CMP201004, CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0721T	QUAN CT TISS CHARAC I&R W/O CNCRNT CT EXAM	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0722T	QUAN CT TISS CHARAC I&R W/CNCRNT CT EXAM	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0723T	QMRCP W/O DIAGNOSTIC MRI SM ANATOMY DRG SM SESS	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0724T	QMRCP W/DIAGNOSTIC MRI SAME ANATOMY	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0725T	VESTIBULAR DEVICE IMPLANTATION UNILATERAL	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0726T	REMOVAL IMPLANTED VESTIBULAR DEVICE UNILATERAL	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0727T	RMVL&RPLCMT IMPLANTED VESTIBULAR DEVICE UNI	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		

Codes	Code Description	Medical Mutual Commercial	Medical Mutual Commercial Criteria	Medicare Advantage	Medicare Advantage Criteria	Details/Notes
0728T	DX ALYS VESTIBULAR IMPLANT UNILATERAL 1ST PRGRMG	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0729T	DX ALYS VESTIBULAR IMPLANT UNI SBSQ PRGRMG	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0730T	TRABECULOTOMY BY LASER, INCLUDING OPTICAL COHERENCE TOMOGRAPHY (OCT) GUIDANCE	NON-COVERED	CMP201721, CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0731T	AUGMENTATIVE AI-BASED FACIAL PHENOTYPE A/R	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0732T	IMMUNOTHERAPY ADMN WITH ELECTROPORATION IM	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0733T	REM R-T MTN CAP NREHAB THER SPLY&TECH SPRT 30D	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0734T	REM R-T MTN CAP NREHAB THER TX MGMT SVCS CAL MO	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0735T	PREPJ TUMOR CAVITY IORT CNCRNT W/PRIM CRANIOTOMY	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0736T	COLONIC LAVAGE 35+L WATER W/INDUCED DEFECATION	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0737T	XENOGRAFT IMPLANTATION INTO ARTICULAR SURFACE	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0738T	TX PLANNING MAG FLD INDCTJ ABLTJ MAL PRST8 TISS	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0739T	ABLATION MAL PRST8 TISS MAGNETIC FIELD INDUCTION	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0740T	REM AUTON ALG INSULIN DOSE 1ST SETUP& PT EDUCAJ	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0741T	REM AUTON ALG NSLN DOS CAL SW DATA COLL TRANSMIS	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0742T	AQMBF SPECT W/EXERCISE/RX STRESS & REST	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0743T	BONE STRENGTH & FRACTURE RSK CNCRNT VRT FX ASSMT	NON-COVERED	CMP94022, CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0744T	INSERTION BIOPROSTHETIC VALVE OPEN FEMORAL VEIN	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0745T	CAR FCL ABLTJ RADJ ARRHYT N-INVAS LOCLZJ & MAPG	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0746T	CAR FCL ABLTJ RADJ ARRHYT CONV LOCLZJ & MAPG	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0748T	NJX STEM CLL PRDCT PERIANAL PERIFISTULAR SFT TIS	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0749T	B1 STR & FX RISK ASSESSMENT USING DXR-BMD ALYS	NON-COVERED	CMP94022, CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0750T	B1 STR&FX RSK ASSMT DXR-BMD ALYS W/1VW XRAY HAND	NON-COVERED	CMP94022, CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0751T	DGTZ GLASS MCRSCP SLD LEVEL II SURG PATH	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0752T	DGTZ GLASS MCRSCP SLD LEVEL III SURG PATH	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0753T	DGTZ GLASS MCRSCP SLD LEVEL IV SURG PATH	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0754T	DGTZ GLASS MCRSCP SLD LEVEL V SURG PATH	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0755T	DGTZ GLASS MCRSCP SLD LEVEL VI SURG PATH	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0756T	DGTZ GLASS MCRSCP SLD SPEC STAIN GRP I MICROORG	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0757T	DGTZ GLASS MCRSCP SLD SPEC STAIN GRP II ALL OTH	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0758T	DGTZ GLASS MCRSCP SLD SPEC STAIN HCHEM STAIN	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0759T	DGTZ GLAS MCRSCP SLD SPEC STN GRP III NZM CONST	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0760T	DGTZ GLASS MCRSCP SLD IMHCHEM/IMCYTCHM 1ST 1STN	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0761T	DGTZ GLASS MCRSCP SLD IMHCHEM/IMCYTCHM EA ADDL 1	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0762T	DGTZ GLS MCRSCP SLD IMHCHEM/IMCTCHM EA MULT ANTB	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0763T	DGTZ GLASS MCRSCP SLD M/PHMTRC ALYS TUM IMHCHEM	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0764T	ASSTV ALG ECG RSK-BASED ASSMT RELATED CNCRT ECG	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0765T	ASSTV ALG ECG RSK-BASED ASSMT RELATED PREV ECG	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0766T	TC MAG STIMJ FCSD LW FRQ EMGNT PLS PN 1ST NERVE	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0767T	TC MAG STIMJ FCSD LW FRQ EMGNT PLS PN EA ADD NRV	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0770T	VIRTUAL REALITY TECHNOLOGY TO ASSIST THERAPY	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0771T	VR PX DISSOC SVC SAME PHYS/QHP 1ST 15 MIN 5YR/>	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0772T	VR PX DISSOC SVC SAME PHYS/QHP EA ADDL 15 MIN	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0773T	VR PX DISSOC SVC OTH PHYS/QHP 1ST 15 MIN 5YR/>	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0774T	VR PX DISSOC SVC OTHER PHYS/QHP EA ADDL 15 MIN	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0776T	THERAPEUTIC INDUCTION OF INTRA-BRAIN HYPOTHERMIA	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0777T	R-T PRESSURE SENSING EPIDURAL GUIDANCE SYSTEM	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0778T	SMMG CNCRNT APPL IMU SNR MEAS ROM POST GAIT MUSC	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0779T	GI MYOELECTRICAL ACTIVITY STUDY STMCH-COLON I&R	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0781T	BRNCHSC RF DSTRJ PULM NRV BI MAINSTEM BRONCHI	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0782T	BRNCHSC RF DSTRJ PULM NRV UNI MAINSTEM BRONCHUS	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0783T	TC AURICULAR NSTIMJ SETUP CALIBRATION &PT EDUCAJ	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0784T	INSERTION OR REPLACEMENT OF PERCUTANEOUS ELECTRODE ARRAY, SPINAL, WITH INTEGRATED NEUROSTIMULATOR, INCLUDING IMAGING GUIDANCE, WHEN PERFORMED	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0785T	REVISION OR REMOVAL OF NEUROSTIMULATOR ELECTRODE ARRAY, SPINAL, WITH INTEGRATED NEUROSTIMULATOR	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0786T	INSERTION OR REPLACEMENT OF PERCUTANEOUS ELECTRODE ARRAY, SACRAL, WITH INTEGRATED NEUROSTIMULATOR, INCLUDING IMAGING GUIDANCE, WHEN PERFORMED	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0787T	REVISION OR REMOVAL OF NEUROSTIMULATOR ELECTRODE ARRAY, SACRAL, WITH INTEGRATED NEUROSTIMULATOR	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		

Codes	Code Description	Medical Mutual Commercial	Medical Mutual Commercial Criteria	Medicare Advantage	Medicare Advantage Criteria	Details/Notes
0788T	ELECTRONIC ANALYSIS WITH SIMPLE PROGRAMMING OF IMPLANTED INTEGRATED NEUROSTIMULATION SYSTEM (EG, ELECTRODE ARRAY AND RECEIVER), INCLUDING CONTACT GROUP(S), AMPLITUDE, PULSE WIDTH, FREQUENCY (HZ), ON/OFF CYCLING, BURST, DOSE LOCKOUT, PATIENT-SELECTABLE PARAMETERS, RESPONSIVE NEUROSTIMULATION, DETECTION ALGORITHMS, CLOSED-LOOP PARAMETERS, AND PASSIVE PARAMETERS, WHEN PERFORMED BY PHYSICIAN OR OTHER QUALIFIED HEALTH CARE PROFESSIONAL, SPINAL CORD OR SACRAL NERVE, 1-3 PARAMETERS	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0789T	ELECTRONIC ANALYSIS WITH COMPLEX PROGRAMMING OF IMPLANTED INTEGRATED NEUROSTIMULATION SYSTEM (EG, ELECTRODE ARRAY AND RECEIVER), INCLUDING CONTACT GROUP(S), AMPLITUDE, PULSE WIDTH, FREQUENCY (HZ), ON/OFF CYCLING, BURST, DOSE LOCKOUT, PATIENT-SELECTABLE PARAMETERS, RESPONSIVE NEUROSTIMULATION, DETECTION ALGORITHMS, CLOSED-LOOP PARAMETERS, AND PASSIVE PARAMETERS, WHEN PERFORMED BY PHYSICIAN OR OTHER QUALIFIED HEALTH CARE PROFESSIONAL, SPINAL CORD OR SACRAL NERVE, 4 OR MORE PARAMETERS	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0791T	MOTOR-COGNITIVE, SEMI-IMMERSIVE VIRTUAL REALITYFACILITATED GAIT TRAINING, EACH 15 MINUTES	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0792T	APPLICATION OF SILVER DIAMINE FLUORIDE 38%, BY A PHYSICIAN OR OTHER QUALIFIED HEALTH CARE PROFESSIONAL	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0793T	PERCUTANEOUS TRANSCATHETER THERMAL ABLATION OF NERVES INNERVATING THE PULMONARY ARTERIES, INCLUDING RIGHT HEART CATHETERIZATION, PULMONARY ARTERY ANGIOGRAPHY, AND ALL IMAGING GUIDANCE	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0794T	PATIENT-SPECIFIC, ASSISTIVE, RULES-BASED ALGORITHM FOR RANKING PHARMACO-ONCOLOGIC TREATMENT OPTIONS BASED ON THE PATIENTS TUMOR-SPECIFIC CAN CER MARKER INFORMATION OBTAINED FROM PRIOR MOLECULAR PATHOLOGY, IMMUNOHISTOCHEMICAL, OR OTHER PATHOLOGY RESULTS WHICH HAVE BEEN PREVIOUSLY INTERPRETED AND REPORTED SEPARATELY	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0805T	TRANSCATHETER SUPERIOR AND INFERIOR VENA CAVA PROSTHETIC VALVE IMPLANTATION (IE, CAVAL VALVE IMPLANTATION (CAVI)); PERCUTANEOUS FEMORAL VEIN APPROACH	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0806T	OPEN FEMORAL VEIN APPROACH	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0807T	PULMONARY TISSUE VENTILATION ANALYSIS USING SOFTWARE-BASED PROCESSING OF DATA FROM SEPARATELY CAPTURED CINEFLUOROGRAPH IMAGES; IN COMBINATIONWITH PREVIOUSLY ACQUIRED COMPUTED TOMOGRAPHY (CT) IMAGES, INCLUDING DATA PREPARATION AND TRANSMISSION, QUANTIFICATION OF PULMONARY TISSUE VENTILATION, DATA REVIEW, INTERPRETATION AND REPORT	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0808T	IN COMBINATION WITH COMPUTED TOMOGRAPHY (CT) IMAGES TAKEN FOR THE PURPOSE OF PULMONARY TISSUE VENTILATION ANALYSIS, INCLUDING DATA PREPARATION AND TRANSMISSION, QUANTIFICATION OF PULMONARY TISSUE VENTILATION, DATA REVIEW, INTERPRETATION AND REPORT	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0809T	arthrodesis of the sacroiliac joint using a percutaneous or minimally invasive approach with image guidance, placement of transfixing devices, and intra-articular implants.	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0810T	SUBRETINAL INJECTION OF A PHARMACOLOGIC AGENT, INCLUDING VITRECTOMY AND 1 OR MORE RETINOTOMIES	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0811T	REM MULTI DAY CPLX UROFLOWMETRY SETUP&PT EDUCAJ	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0812T	REM MULTI DAY CPLX UROFLOWMETRY DEV SPLY W/REPRT	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0813T	EGD FLX TRNSORL VOL ADJMT NTRGSTR BARIATRIC BALO	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0814T	PERQ NJX CALCIUM BIOD OSTEOCONDUCTIVE MATRL FEM	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0815T	US REMS B1 DNS&FX RSK ASSMT 1+SITE HIPS PLVS/SPI	NON-COVERED	CMP94022, CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0820T	CONT IP MNTR&IVNTJ PSYCHEDELIC MED THERAPY 1ST	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0821T	CONT IP MNTR&IVNTJ PSYCHEDELIC MED THERAPY 2ND	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0822T	CONT IP MNTR&IVNTJ PSYCHEDELIC MED THERAPY STAFF	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0827T	DGTZ GLASS MCRSCP SLD CYTP SMEARS W/INTERPJ	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0828T	DGTZ GLASS MCRSCP SLD CYTP SMPL FLTR METH INTERP	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0829T	DGTZ GLASS MCRSCP SLD CYTP CONCTRJ TQ SMR&INTERP	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0830T	DGTZ GLASS MCRSCP SLD CYTP SLCTV CELL NHNCMNT TQ	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0831T	DGTZ GLASS MCRSCP SLD CYTP CERVICAL OR VAGINAL	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		

Codes	Code Description	Medical Mutual Commercial	Medical Mutual Commercial Criteria	Medicare Advantage	Medicare Advantage Criteria	Details/Notes
0832T	DGTZ GLASS MCRSCP SLD CYTP SMR OTH SRC SCR&NTRP	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0833T	DGTZ GLASS MCRSCP SLD CYTP SMR OTH SRC PREP SCR	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0834T	DGTZ GLASS MCRSCP SLD CYTP SMR OTH SRC EXTND STD	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0835T	DGTZ GLASS MCRSCP SLD CYTP FNA IMMT 1ST EPSD EA	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0836T	DGTZ GLASS MCRSCP SLD CYTP FNA IMMT EA SEP ADDL	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0837T	DGTZ GLASS MCRSCP SLD CYTP FNA INTERPJ&REPRT	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0838T	DGTZ GLS MCRSCP SLD CNSLT&REPRT REF SLD PREP ELS	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0839T	DGTZ GLS MCRSCP SLD CNSLT&REPRT REF MAT PREP SLD	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0840T	DGTZ GLS MCRSCP SLD FOR CONSLTJ COMPREHENSIVE	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0841T	DGTZ GLS MCRSCP SLD PATH CNSLT DRG SRG 1ST TIS 1	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0842T	DGTZ GLS MCRSCP SLD PATH CNSLT DRG SURG EA ADDL	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0843T	DGTZ GLS MCRSCP SLD PATH CNSLT SURG CYTL XM 1ST	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0844T	DGTZ GLS MCRSCP SLD PATH CNSLT SURG CYTL XM EA	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0845T	DGTZ GLS MCRSCP SLD IMFLUOR 1ST SINGLE ANTB STN	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0846T	DGTZ GLS MCRSCP SLD IMFLUOR EACH ADDL 1 ANTB STN	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0847T	DGTZ GLS MCRSCP SLD XM&SLCTN ARCH TIS MOLEC ALYS	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0848T	DGTZ GLS MCRSCP SLD ISH 1ST SINGLE PROBE STAIN	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0849T	DGTZ GLS MCRSCP SLD ISH EA ADDL 1 PROBE STAIN	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0850T	DGTZ GLS MCRSCP SLD ISH EA MULT PROBE STAIN	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0851T	DGTZ GLS MCRSCP SLD M/PHMTRC ISH 1ST 1 PROBE STN	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0852T	DGTZ GLS MCRSCP SLD M/PHMTRC ISH EA ADD 1PRB STN	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0853T	DGTZ GLS MCRSCP SLD M/PHMTRC ISH EA MULT PRB STN	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0854T	DGTZ GLS MCRSCP SLD BLOOD SMEAR PERIPHERAL I&R	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0855T	DGTZ GLS MCRSCP SLD BONE MARROW SMEAR INTERPJ	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0856T	DGTZ GLS MCRSCP SLD ELECTRON MICROSCOPY DX	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0857T	OPTO-ACOUSTIC IMG BREAST UNI AUGMNT ALYS&REPRT	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0858T	XTRNL TRNSCRANL MAG STIMJ MEAS EVOKD CRTCL PTNTL	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0861T	REMOVAL PG WCS LV PACING BOTH COMPONENTS	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0862T	RELOCATION PG WCS LV PACG BATTERY COMPONENT ONLY	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0863T	RELOCATION PG WCS LV PACG TRANSMITTR COMPNT ONLY	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0864T	LOW INTENSITY ESWT CORPUS CAVERNOSUM LOW ENERGY	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0867T	Transperineal laser ablation of benign prostatic hyperplasia, including imaging guidance; prostate volume greater or equal to 50 mL	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0868T	High-resolution gastric electrophysiology mapping with simultaneous patient symptom profiling, with interpretation and report	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0869T	INJECTION(S), BONE-SUBSTITUTE MATERIAL FOR BONE AND/OR SOFT TISSUE HARDWARE FIXATION AUGMENTATION, INCLUDING INTRAOPERATIVE IMAGING GUIDANCE, WHEN PERFORMED	NON-COVERED	CMP2019-B, CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0870T	Implantation of subcutaneous peritoneal ascites pump system, percutaneous, including pump-pocket creation, insertion of tunneled indwelling bladder and peritoneal catheters with pump connections, including all imaging and initial programming, when performed	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0871T	Replacement of a subcutaneous peritoneal ascites pump, including reconnection between pump and indwelling bladder and peritoneal catheters, including initial programming and imaging, when performed	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0872T	Replacement of indwelling bladder and peritoneal catheters, including tunneling of catheter(s) and connection with previously implanted peritoneal ascites pump, including imaging and programming, when performed	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0873T	Revision of a subcutaneously implanted peritoneal ascites pump system, any component (ascites pump, associated peritoneal catheter, associated bladder catheter), including imaging and programming, when performed	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0874T	Removal of a peritoneal ascites pump system, including implanted peritoneal ascites pump and indwelling bladder and peritoneal catheters	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0875T	Programming of subcutaneously implanted peritoneal ascites pump system by physician or other qualified health care professional	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0876T	Duplex scan of hemodialysis fistula, computer-aided, limited (volume flow, diameter, and depth, including only body of fistula)	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0877T	Augmentative analysis of chest computed tomography (CT) imaging data to provide categorical diagnostic subtype classification of interstitial lung disease; obtained without concurrent CT examination of any structure contained in previously acquired diagnostic imaging	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		

Codes	Code Description	Medical Mutual Commercial	Medical Mutual Commercial Criteria	Medicare Advantage	Medicare Advantage Criteria	Details/Notes
0878T	Augmentative analysis of chest computed tomography (CT) imaging data to provide categorical diagnostic subtype classification of interstitial lung disease; obtained without concurrent CT examination of any structure contained in previously acquired diagnostic imaging; obtained with concurrent CT examination of the same structure	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0879T	Augmentative analysis of chest computed tomography (CT) imaging data to provide categorical diagnostic subtype classification of interstitial lung disease; obtained without concurrent CT examination of any structure contained in previously acquired diagnostic imaging; radiological data preparation and transmission	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0880T	Augmentative analysis of chest computed tomography (CT) imaging data to provide categorical diagnostic subtype classification of interstitial lung disease; obtained without concurrent CT examination of any structure contained in previously acquired diagnostic imaging; physician or other qualified health care professional interpretation and report	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0881T	Cryotherapy of the oral cavity using temperature regulated fluid cooling system, including placement of an oral device, monitoring of patient tolerance to treatment, and removal of the oral device	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0882T	Intraoperative therapeutic electrical stimulation of peripheral nerve to promote nerve regeneration, including lead placement and removal, upper extremity, minimum of 10 minutes; initial nerve (List separately in addition to code for primary procedure) (Use 0882T in conjunction with 64702, 64704, 64708, 64713, 64718, 64719, 64721, 64831, 64834, 64835, 64836, 64856, 64857, 64892, 64893, 64895, 64896, 64897, 64898, 64905, 64910, 64911, 64912)	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0883T	Intraoperative therapeutic electrical stimulation of peripheral nerve to promote nerve regeneration, including lead placement and removal, upper extremity, minimum of 10 minutes; initial nerve (List separately in addition to code for primary procedure); each additional nerve (List separately in addition to code for primary procedure) (Use 0883T in conjunction with 0882T)	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0884T	Esophagoscopy, flexible, transoral, with initial transendoscopic mechanical dilation (eg, nondrug-coated balloon) followed by therapeutic drug delivery by drug-coated balloon catheter for esophageal stricture, including fluoroscopic guidance, when performed	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0885T	Colonoscopy, flexible, with initial transendoscopic mechanical dilation (eg, nondrug-coated balloon) followed by therapeutic drug delivery by drug-coated balloon catheter for colonic stricture, including fluoroscopic guidance, when performed	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0886T	Sigmoidoscopy, flexible, with initial transendoscopic mechanical dilation (eg, nondrug-coated balloon) followed by therapeutic drug delivery by drug-coated balloon catheter for colonic stricture, including fluoroscopic guidance, when performed	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0887T	End-tidal control of inhaled anesthetic agents and oxygen to assist anesthesia care delivery (List separately in addition to code for primary procedure) (Use 0887T in conjunction with 00100-01999)	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0888T	Histotripsy (i.e., non-thermal ablation via acoustic energy delivery) of malignant renal tissue, including imaging guidance	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0889T	Personalized target development for accelerated, repetitive high-dose functional connectivity MRI–guided theta-burst stimulation derived from a structural and resting-state functional MRI, including data preparation and transmission, generation of the target, motor threshold–starting location, neuronavigation files and target report, review and interpretation	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0890T	Accelerated, repetitive high-dose functional connectivity MRI–guided theta-burst stimulation, including target assessment, initial motor threshold determination, neuronavigation, delivery and management, initial treatment day	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		

Codes	Code Description	Medical Mutual Commercial	Medical Mutual Commercial Criteria	Medicare Advantage	Medicare Advantage Criteria	Details/Notes
0891T	Accelerated, repetitive high-dose functional connectivity MRI–guided theta-burst stimulation, including neuronavigation, delivery and management, subsequent treatment day	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0892T	Accelerated, repetitive high-dose functional connectivity MRI–guided theta-burst stimulation, including neuronavigation, delivery and management, subsequent motor threshold redetermination with delivery and management, per treatment day	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0893T	Noninvasive assessment of blood oxygenation, gas exchange efficiency, and cardiorespiratory status, with physician or other qualified health care professional interpretation and report	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0894T	Cannulation of the liver allograft in preparation for connection to the normothermic perfusion device and decannulation of the liver allograft following normothermic perfusion	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0895T	Connection of liver allograft to normothermic machine perfusion device, hemostasis control; initial 4 hours of monitoring time, including hourly physiological and laboratory assessments (e.g., perfusate temperature, perfusate pH, hemodynamic parameters, bile production, bile pH, bile glucose, biliary bicarbonate, lactate levels, macroscopic assessment)	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0896T	Connection of liver allograft to normothermic machine perfusion device, hemostasis control; initial 4 hours of monitoring time, including hourly physiological and laboratory assessments (e.g., perfusate temperature, perfusate pH, hemodynamic parameters, bile production, bile pH, bile glucose, biliary bicarbonate, lactate levels, macroscopic assessment); each additional hour, including physiological and laboratory assessments (e.g., perfusate temperature, perfusate pH, hemodynamic parameters, bile production, bile pH, bile glucose, biliary bicarbonate, lactate levels, macroscopic assessment) (List separately in addition to code for primary procedure)	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0897T	Noninvasive augmentative arrhythmia analysis derived from quantitative computational cardiac arrhythmia simulations, based on selected intervals of interest from 12-lead electrocardiogram and uploaded clinical parameters, including uploading clinical parameters with interpretation and report	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0898T	Noninvasive prostate cancer estimation map, derived from augmentative analysis of image-guided fusion biopsy and pathology, including visualization of margin volume and location, with margin determination and physician interpretation and report	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0899T	Noninvasive determination of absolute quantitation of myocardial blood flow (AQMBF), derived from augmentative algorithmic analysis of the dataset acquired via contrast cardiac magnetic resonance (CMR), pharmacologic stress, with interpretation and report by a physician or other qualified health care professional (List separately in addition to code for primary procedure) (Use 0899T in conjunction with 75563)	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0900T	Noninvasive estimate of absolute quantitation of myocardial blood flow (AQMBF), derived from assistive algorithmic analysis of the dataset acquired via contrast cardiac magnetic resonance (CMR), pharmacologic stress, with interpretation and report by a physician or other qualified health care professional (List separately in addition to code for primary procedure) (Use 0900T in conjunction with 75563)	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0901T	PLACEMENT BONE MARROW SAMPLING PORT W/IMG GDN	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0902T	QTC INTERVAL AUGMNT ALG ALYS XTRNL MOBILE ECG	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0903T	ECG ALGORITHMICALLY GEN 12 LEAD REDUCED LEAD I&R	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0904T	ECG ALGORITHMICALLY GEN 12 LD RDCD LD TRCG ONLY	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0905T	ECG ALGORITHMICALLY GEN 12 LD RDCD LD I&R ONLY	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0906T	COMS THERAPY WND ASSMT&DR 1ST APPL <=50 SQ CM	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0907T	COMS THERAPY WND ASSMT&DR EA ADDL APPL<=50 SQ CM	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0908T	OPEN IMPLTJ INT NEUROSTIMULATION SYS VAGUS NERVE	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0909T	REPLACEMENT INT NEUROSTIMULATION SYS VAGUS NERVE	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0910T	REMOVAL INT NEUROSTIMULATION SYS VAGUS NERVE	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0911T	ELEC ALYS INT NSTIMJ SYS VAGUS NRV W/O PRGRMG	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0912T	ELEC ALYS INT NSTIMJ SYS VAGUS NRV W/SMPL PRGRMG	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		

Codes	Code Description	Medical Mutual Commercial	Medical Mutual Commercial Criteria	Medicare Advantage	Medicare Advantage Criteria	Details/Notes
0913T	PERQ TCAT THER RX DLVR NTRAC RX BALO 1 MAJ C ART	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0914T	PERQ TCAT THER RX DLVR NTRAC RX BALO SEPARATE	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0915T	INSJ PERM CCM-D SYS PG&DUAL TRANSVNS ELTRDS/LDS	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0916T	INSERTION PERM CCM-D SYSTEM PULSE GENERATOR ONLY	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0917T	INSJ PERM CCM-D SYS 1 TRANSVNS LEAD ONLY	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0918T	INSJ PERM CCM-D SYS DUAL TRANSVNS LEADS ONLY	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0919T	REMOVAL PERM CCM-D SYSTEM PULSE GENERATOR ONLY	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0920T	RMVL PERM CCM-D SYS 1 TRANSVNS PACING LEAD ONLY	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0921T	RMVL PERM CCM-D SYS 1 TRANSVNS DFB LEAD ONLY	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0922T	RMVL PERM CCM-D SYS DUAL TRANSVNS LEADS ONLY	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0923T	RMVL&RPLCMT PERMANENT CCM-D PULSE GENERATOR ONLY	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0924T	REPOSITIONING PREV IMPL CCM-D TRANSVNS ELTRD/LD	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0925T	RELOCATION SKIN POCKET IMPLANTED CCM-D PG	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0926T	PROGRAMMING DEVICE EVAL IMPL CCM-D SYS IN PERSON	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0927T	INTERROG DEV EVAL IMPL CCM-D SYSTEM IN PERSON	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0928T	REMOTE INTERROG DEV EVAL CCM-D SYS <90D PHYS/QHP	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0929T	REMOTE INTERROG DEV EVAL CCM-D SYS <90D TECH	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0930T	ELECTROPHYSIOLOGIC EVAL CCM-D LEADS AT 1ST IMPL	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0931T	ELECTROPHYSIOLOGIC EVAL CCM-D LEADS SEPARATE	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0932T	N-INVAS DETCJ HEART FAILURE DRV AUGMNT ALYS ECHO	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0933T	TCAT IMPLT WRLS L ATR PRS SNR L-T L ATR PRS MNTR	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0934T	REMOTE MNTR WIRELESS L ATRIAL PRESSURE SNR<30 D	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0935T	CYSTO W/RNL PEL SYMPATHETIC DNRVTJ RF ABLTJ BI	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0936T	PHOTOBIOMODULATION THERAPY RETINA SINGLE SESSION	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0937T	XTRNL ECG REC>15D<30D REC SCAN ALYS RVW&INTERPJ	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0938T	XTRNL ECG REC>15D<30D RECORDING	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0939T	XTRNL ECG REC>15D<30D SCANNING ANALYSIS W/REPORT	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0940T	XTRNL ECG REC>15D<30D REVIEW&INTERPJ PHYS/QHP	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0941T	CYSTO FLX INSJ&XPNSJ PROSTATIC URTL SCAFFOLD	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0942T	CYSTO FLX RMVL&RPLCMT PROSTATIC URTL SCAFFOLD	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0943T	CYSTO FLX REMOVAL PROSTATIC URETHRAL SCAFFOLD	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0944T	3D CONTOUR SIMULAJ TRGT LVR LES&MRGN MICRWV ABLT	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0945T	INTRAOP ASMT ABNL TUM TIS IN-VIVO FLWG PRTL MAST	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0946T	ORTHOPEDIC IMPLT MVMT ALYS PAIRED CT TRGT STRUX	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0947T	MRGFUS STRTCTC BLD-BRN BARR DISRPJ MBUBB RSN8TR	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0552U	REPRODUCTIVE MEDICINE (PREIMPLANTATION GENETIC ASSESSMENT), ANALYSIS FOR KNOWN GENETIC DISORDERS FROM TROPHECTODERM BIOPSY, LINKAGE ANALYSIS OF DISEASE-CAUSING LOCUS, AND WHEN POSSIBLE, TARGETED MUTATION ANALYSIS FOR KNOWN FAMILIAL VARIANT, REPORTED AS LOW-RISK OR HIGH-RISK FOR FAMILIAL GENETIC DISORDER	NON-COVERED	CMP201303	PRIOR AUTHORIZATION NOT REQUIRED		
0553U	REPRODUCTIVE MEDICINE (PREIMPLANTATION GENETIC ASSESSMENT), ANALYSIS OF 24 CHROMOSOMES USING DNA GENOMIC SEQUENCE ANALYSIS FROM EMBRYONIC TROPHECTODERM FOR STRUCTURAL REARRANGEMENTS, ANEUPLOIDY, AND A MITOCHONDRIAL DNA SCORE, RESULTS REPORTED AS NORMAL/BALANCED (EUPLOIDY/BALANCED), UNBALANCED STRUCTURAL REARRANGEMENT, MONOSOMY, TRISOMY, SEGMENTAL ANEUPLOIDY, OR MOSAIC, PER EMBRYO TESTED	NON-COVERED	CMP201303	PRIOR AUTHORIZATION NOT REQUIRED		
0554U	REPRODUCTIVE MEDICINE (PREIMPLANTATION GENETIC ASSESSMENT), ANALYSIS OF 24 CHROMOSOMES USING DNA GENOMIC SEQUENCE ANALYSIS FROM TROPHECTODERM BIOPSY FOR ANEUPLOIDY, PLOIDY, A MITOCHONDRIAL DNA SCORE, AND EMBRYO QUALITY CONTROL, RESULTS REPORTED AS NORMAL (EUPLOIDY), MONOSOMY, TRISOMY, SEGMENTAL ANEUPLOIDY, TRIPLOID, HAPLOID, OR MOSAIC, WITH QUALITY CONTROL RESULTS REPORTED AS CONTAMINATION DETECTED OR INCONSISTENT COHORT WHEN APPLICABLE, PER EMBRYO TESTED	NON-COVERED	CMP201303	PRIOR AUTHORIZATION NOT REQUIRED		

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0555U	REPRODUCTIVE MEDICINE (PREIMPLANTATION GENETIC ASSESSMENT), ANALYSIS OF 24 CHROMOSOMES USING DNA GENOMIC SEQUENCE ANALYSIS FROM EMBRYONIC TROPHECTODERM FOR STRUCTURAL REARRANGEMENTS, ANEUPLOIDY, PLOIDY, A MITOCHONDRIAL DNA SCORE, AND EMBRYO QUALITY CONTROL, RESULTS REPORTED AS NORMAL/BALANCED (EUPLOIDY/BALANCED), UNBALANCED STRUCTURAL REARRANGEMENT, MONOSOMY, TRISOMY, SEGMENTAL ANEUPLOIDY, TRIPLOID, HAPLOID, OR MOSAIC, WITH QUALITY CONTROL RESULTS REPORTED AS CONTAMINATION DETECTED OR INCONSISTENT COHORT WHEN APPLICABLE, PER EMBRYO TESTED	NON-COVERED	CMP201303	PRIOR AUTHORIZATION NOT REQUIRED		
0560U	ONCOLOGY (MINIMAL RESIDUAL DISEASE (MRD)), GENOMIC SEQUENCE ANALYSIS, CELL-FREE DNA, WHOLE BLOOD AND TUMOR TISSUE, BASELINE ASSESSMENT FOR DESIGN AND CONSTRUCTION OF A PERSONALIZED VARIANT PANEL TO EVALUATE CURRENT MRD AND FOR COMPARISON TO SUBSEQUENT MRD ASSESSMENTS	NON-COVERED	CMP201303	PRIOR AUTHORIZATION NOT REQUIRED		
0561U	ONCOLOGY (MINIMAL RESIDUAL DISEASE (MRD)), GENOMIC SEQUENCE ANALYSIS, CELL-FREE DNA, WHOLE BLOOD, SUBSEQUENT ASSESSMENT WITH COMPARISON TO INITIAL ASSESSMENT TO EVALUATE FOR MRD	NON-COVERED	CMP201303	PRIOR AUTHORIZATION NOT REQUIRED		
0562U	ONCOLOGY (SOLID TUMOR), TARGETED GENOMIC SEQUENCE ANALYSIS, 33 GENES, DETECTION OF SINGLE-NUCLEOTIDE VARIANTS (SNVS), INSERTIONS AND DELETIONS, COPY-NUMBER AMPLIFICATIONS, AND TRANSLOCATIONS IN HUMAN GENOMIC CIRCULATING CELL-FREE DNA, PLASMA, REPORTED AS PRESENCE OF ACTIONABLE VARIANTS	NON-COVERED	CMP201303	PRIOR AUTHORIZATION NOT REQUIRED		
0565U	ONCOLOGY (HEPATOCELLULAR CARCINOMA), NEXT-GENERATION SEQUENCING METHYLATION PATTERN ASSAY TO DETECT 6626 EPIGENETIC ALTERATIONS, CELL-FREE DNA, PLASMA, ALGORITHM REPORTED AS CANCER SIGNAL DETECTED OR NOT DETECTED	NON-COVERED	CMP201303	PRIOR AUTHORIZATION NOT REQUIRED		
0566U	ONCOLOGY (LUNG), QPCR-BASED ANALYSIS OF 13 DIFFERENTIALLY METHYLATED REGIONS (CCDC181, HOXA7, LRRC8A, MARCHF11, MIR129-2, NCOR2, PANTR1, PRKCB, SLC9A3, TBR1_2, TRAP1, VWC2, ZNF781), PLEURAL FLUID, ALGORITHM REPORTED AS A QUALITATIVE RESULT	NON-COVERED	CMP201303	PRIOR AUTHORIZATION NOT REQUIRED		
0567U	RARE DISEASES (CONSTITUTIONAL/HERITABLE DISORDERS), WHOLE-GENOME SEQUENCE ANALYSIS COMBINATION OF SHORT AND LONG READS, FOR SINGLE-NUCLEOTIDE VARIANTS, INSERTIONS/DELETIONS AND CHARACTERIZED INTRONIC VARIANTS, COPY-NUMBER VARIANTS, DUPLICATIONS/DELETIONS, MOBILE ELEMENT INSERTIONS, RUNS OF HOMOZYGOSITY, ANEUPLOIDY, AND INVERSIONS, MITOCHONDRIAL DNA SEQUENCE AND DELETIONS, SHORT TANDEM REPEAT GENES, METHYLATION STATUS OF SELECTED REGIONS, BLOOD, SALIVA, AMNIOCENTESIS, CHORIONIC VILLUS SAMPLE OR TISSUE, IDENTIFICATION AND CATEGORIZATION OF GENETIC VARIANTS	NON-COVERED	CMP201303	PRIOR AUTHORIZATION NOT REQUIRED		
0569U	ONCOLOGY (SOLID TUMOR), NEXT-GENERATION SEQUENCING ANALYSIS OF TUMOR METHYLATION MARKERS (>20000 DIFFERENTIALLY METHYLATED REGIONS) PRESENT IN CELL-FREE CIRCULATING TUMOR DNA (CTDNA), WHOLE BLOOD, ALGORITHM REPORTED AS PRESENCE OR ABSENCE OF CTDNA WITH TUMOR FRACTION, IF APPROPRIATE	NON-COVERED	CMP201303	PRIOR AUTHORIZATION NOT REQUIRED		
0571U	ONCOLOGY (SOLID TUMOR), DNA (80 GENES) AND RNA (10 GENES), BY NEXT-GENERATION SEQUENCING, PLASMA, INCLUDING SINGLE-NUCLEOTIDE VARIANTS, INSERTIONS/DELETIONS, COPY-NUMBER ALTERATIONS, MICROSATELLITE INSTABILITY, AND FUSIONS, REPORTED AS CLINICALLY ACTIONABLE VARIANTS	NON-COVERED	CMP201303	PRIOR AUTHORIZATION NOT REQUIRED		
0572U	ONCOLOGY (PROSTATE), HIGH-THROUGHPUT TELOMERE LENGTH QUANTIFICATION BY FISH, WHOLE BLOOD, DIAGNOSTIC ALGORITHM REPORTED AS RISK OF PROSTATE CANCER	NON-COVERED	CMP201303	PRIOR AUTHORIZATION NOT REQUIRED		
0575U	TRANSPLANTATION MEDICINE (LIVER ALLOGRAFT REJECTION), MIRNA GENE EXPRESSION PROFILING BY RT-PCR OF 4 GENES (MIR-122, MIR-885, MIR-23A HOUSEKEEPING, SPIKE-IN CONTROL), SERUM, ALGORITHM REPORTED AS RISK OF LIVER ALLOGRAFT REJECTION	NON-COVERED	CMP201303	PRIOR AUTHORIZATION NOT REQUIRED		

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0576U	TRANSPLANTATION MEDICINE (LIVER ALLOGRAFT REJECTION), QUANTITATIVE DONOR-DERIVED CELL-FREE DNA (CFDNA) BY WHOLE GENOME NEXT-GENERATION SEQUENCING, PLASMA AND MRNA GENE EXPRESSION PROFILING BY MULTIPLEX REAL-TIME PCR OF 56 GENES, WHOLE BLOOD, COMBINED ALGORITHM REPORTED AS A REJECTION RISK SCORE	NON-COVERED	CMP201303	PRIOR AUTHORIZATION NOT REQUIRED		
0577U	ONCOLOGY (OVARIAN), SERUM, ANALYSIS OF 39 GLYCOPROTEINS BY LIQUID CHROMATOGRAPHY WITH TANDEM MASS SPECTROMETRY (LC-MS/MS) IN MULTIPLE REACTION MONITORING MODE, REPORTED AS LIKELIHOOD OF MALIGNANCY	NON-COVERED	CMP201303	PRIOR AUTHORIZATION NOT REQUIRED		
0578U	ONCOLOGY (CUTANEOUS MELANOMA), RNA, GENE EXPRESSION PROFILING BY REAL-TIME QPCR OF 10 GENES (8 CONTENT AND 2 HOUSEKEEPING), UTILIZING FORMALIN-FIXED PARAFFIN-EMBEDDED (FFPE) TISSUE, ALGORITHM REPORTS A BINARY RESULT, EITHER LOW-RISK OR HIGH-RISK FOR SENTINEL LYMPH NODE METASTASIS AND RECURRENCE	NON-COVERED	CMP201303	PRIOR AUTHORIZATION NOT REQUIRED		
0582U	RARE DISEASES (CONSTITUTIONAL DISEASE/HEREDITARY DISORDERS), RAPID WHOLE GENOME DNA SEQUENCING FOR SINGLE-NUCLEOTIDE VARIANTS, INSERTIONS/DELETIONS, COPY NUMBER VARIATIONS, BLOOD, SALIVA, TISSUE SAMPLE, VARIANTS REPORTED	NON-COVERED	CMP201303	PRIOR AUTHORIZATION NOT REQUIRED		
0583U	RARE DISEASES (CONSTITUTIONAL DISEASE/HEREDITARY DISORDERS), RAPID WHOLE GENOME COMPARATOR DNA SEQUENCING FOR SINGLE-NUCLEOTIDE VARIANTS, INSERTIONS/DELETIONS, COPY NUMBER VARIATIONS, BLOOD, SALIVA, TISSUE SAMPLE, VARIANTS REPORTED WITH PROBAND RESULTS (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)	NON-COVERED	CMP201303	PRIOR AUTHORIZATION NOT REQUIRED		
0585U	TARGETED GENOMIC SEQUENCE ANALYSIS PANEL, SOLID ORGAN NEOPLASM, CIRCULATING CELL-FREE DNA (CFDNA) ANALYSIS FROM PLASMA OF 521 GENES, INTERROGATION FOR SEQUENCE VARIANTS, GENE COPY NUMBER AMPLIFICATIONS, GENE REARRANGEMENTS, AND MICROSATELLITE INSTABILITY, REPORT SHOWS IDENTIFIED MUTATIONS, INCLUDING VARIANTS WITH CLINICAL ACTIONABILITY	NON-COVERED	CMP201303	PRIOR AUTHORIZATION NOT REQUIRED		
0586U	ONCOLOGY, MRNA, GENE EXPRESSION PROFILING OF 216 GENES (204 TARGETED AND 12 HOUSEKEEPING GENES), RNA EXPRESSION ANALYSIS, FORMALIN-FIXED PARAFFIN-EMBEDDED (FFPE) TISSUE, QUANTITATIVE, REPORTED AS LOG2 RATIO PER GENE	NON-COVERED	CMP201303	PRIOR AUTHORIZATION NOT REQUIRED		
0591U	ONCOLOGY (PROSTATE CANCER), BIOCHEMICAL ANALYSIS OF 3 PROTEINS (TOTAL PSA, FREE PSA, AND HE4), PLASMA, SERUM, PROGNOSTIC ALGORITHM INCORPORATING 3 PROTEINS AND DIGITAL RECTAL EXAMINATION, RESULTS REPORTED AS A PROBABILITY SCORE FOR CLINICALLY SIGNIFICANT PROSTATE CANCER	NON-COVERED	CMP201303	PRIOR AUTHORIZATION NOT REQUIRED		
0592U	ONCOLOGY (HEMATOLYMPHOID NEOPLASMS), DNA, TARGETED GENOMIC SEQUENCE OF 417 GENES, INTERROGATION FOR GENE FUSIONS, TRANSLOCATIONS, REARRANGEMENTS, UTILIZING FORMALIN-FIXED PARAFFIN-EMBEDDED (FFPE) TUMOR TISSUE, RESULTS REPORT CLINICALLY SIGNIFICANT VARIANT(S)	NON-COVERED	CMP201303	PRIOR AUTHORIZATION NOT REQUIRED		
0597U	ONCOLOGY (BREAST), RNA EXPRESSION PROFILING OF 329 GENES BY TARGETED NEXT-GENERATION SEQUENCING AND 20 PROTEINS BY MULTIPLEX IMMUNOFLUORESCENCE, FORMALIN-FIXED PARAFFIN-EMBEDDED (FFPE) TISSUE, ALGORITHMIC ANALYSES TO DETERMINE TUMOR-RECURRENCE RISK SCORE	NON-COVERED	CMP201303	PRIOR AUTHORIZATION NOT REQUIRED		
26340	MANIPULATION FINGER JOINT UNDER ANES EACH JOINT	NON-COVERED	CMP95029	PRIOR AUTHORIZATION NOT REQUIRED		
64625	RADIOFREQUENCY ABLATION, NERVES INNERVATING THE SACROILIAC JOINT, WITH IMAGE GUIDANCE (IE, FLUOROSCOPY OR COMPUTED TOMOGRAPHY)	NON-COVERED	CMP201537	PRIOR AUTHORIZATION NOT REQUIRED		

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33274	TRANSCATHETER INSERTION OR REPLACEMENT OF PERMANENT LEADLESS PACEMAKER, RIGHT VENTRICULAR, INCLUDING IMAGING GUIDANCE (EG, FLUOROSCOPY, VENOUS ULTRASOUND, VENTRICULOGRAPHY, FEMORAL VENOGRAPHY) AND DEVICE EVALUATION (EG, INTERROGATION OR PROGRAMMING), WHEN PERFORMED	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP202504	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
62264	PERCUTANEOUS LYSIS OF EPIDURAL ADHESIONS USING SOLUTION INJECTION (EG, HYPERTONIC SALINE, ENZYME) OR MECHANICAL MEANS (EG, CATHETER) INCLUDING RADIOLOGIC LOCALIZATION (INCLUDES CONTRAST WHEN ADMINISTERED), MULTIPLE ADHESIOLYSIS SESSIONS; 1 DAY	NON-COVERED	CMP200522	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP 200522	
64553	PERCUTANEOUS IMPLANTATION OF NEUROSTIMULATOR ELECTRODE ARRAY; CRANIAL NERVE	NON-COVERED	MCG B-821-T (CMP202406)	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
64568	INCISION FOR IMPLANTATION OF CRANIAL NERVE (EG, VAGUS NERVE) NEUROSTIMULATOR ELECTRODE ARRAY AND PULSE GENERATOR	NON-COVERED	MCG B-821-T (CMP202406)	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
64624	DESTRUCTION BY NEUROLYTIC AGENT, GENICULAR NERVE BRANCHES INCLUDING IMAGING GUIDANCE, WHEN PERFORMED	NON-COVERED	MCG A-1047 (CMP202407)	PRIOR AUTHORIZATION NOT REQUIRED		
64628	THERMAL DESTRUCTION OF INTRAOSSEOUS BASIVERTEBRAL NERVE, INCLUDING ALL IMAGING GUIDANCE; FIRST 2 VERTEBRAL BODIES, LUMBAR OR SACRAL	NON-COVERED	CMP201537	NON-COVERED	CMP201537	
64629	THERMAL DSTRJ INTRAOSSEOUS BVN EA ADDL LMBR/SAC	NON-COVERED	CMP201537	NON-COVERED	CMP201537	
77091	TBS TECHNICAL CALCULATION ONLY	NON-COVERED	CMP94022	NON-COVERED	CMP94022	
89335	CRYOPRESERVATION, REPRODUCTIVE TISSUE, TESTICULAR	NON-COVERED	CMP202302	PRIOR AUTHORIZATION NOT REQUIRED		
92518	OCULAR VEMP TESTING W/I&R	NON-COVERED	CMP94007	PRIOR AUTHORIZATION NOT REQUIRED		
92519	CERVICAL & OCULAR VEMP TESTING W/I&R	NON-COVERED	CMP94007	PRIOR AUTHORIZATION NOT REQUIRED		
92548	COMPUTERIZED DYNAMIC POSTUROGRAPHY SENSORY ORGANIZATION TEST (CDP-SOT), 6 CONDITIONS (IE, EYES OPEN, EYES CLOSED, VISUAL SWAY, PLATFORM SWAY, EYES CLOSED PLATFORM SWAY, PLATFORM AND VISUAL SWAY), INCLUDING INTERPRETATION AND REPORT;	NON-COVERED	CMP94007	PRIOR AUTHORIZATION NOT REQUIRED		
92549	COMPUTERIZED DYNAMIC POSTUROGRAPHY SENSORY ORGANIZATION TEST (CDP-SOT), 6 CONDITIONS (IE, EYES OPEN, EYES CLOSED, VISUAL SWAY, PLATFORM SWAY, EYES CLOSED PLATFORM SWAY, PLATFORM AND VISUAL SWAY), INCLUDING INTERPRETATION AND REPORT; WITH MOTOR CONTROL TEST (MCT) AND ADAPTATION TEST (ADT)	NON-COVERED	CMP94007	PRIOR AUTHORIZATION NOT REQUIRED		
93740	TEMPERATURE GRADIENT STUDIES	NON-COVERED	CMP201324	PRIOR AUTHORIZATION NOT REQUIRED		
15756	FREE MUSCLE OR MYOCUTANEOUS FLAP WITH MICROVASCULAR ANASTOMOSIS	NON-COVERED FOR CERTAIN INDICATIONS (see note)	CMP202011	PRIOR AUTHORIZATION NOT REQUIRED		
19105	ABLATION, CRYOSURGICAL, OF FIBROADENOMA, INCLUDING ULTRASOUND GUIDANCE, EACH FIBROADENOMA	NON-COVERED	CMP200802	PRIOR AUTHORIZATION NOT REQUIRED		
20560	NEEDLE INSERTION(S) WITHOUT INJECTION(S); 1 OR 2 MUSCLE(S)	NON-COVERED	CMP202009	PRIOR AUTHORIZATION NOT REQUIRED		
20561	NEEDLE INSERTION(S) WITHOUT INJECTION(S); 3 OR MORE MUSCLES	NON-COVERED	CMP202009	PRIOR AUTHORIZATION NOT REQUIRED		
20985	COMPUTER-ASSISTED SURGICAL NAVIGATIONAL PROCEDURE FOR MUSCULOSKELETAL PROCEDURES, IMAGE-LESS (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)	NON-COVERED	CMP2019-D	NON-COVERED	CMP2019-D	
21073	MANIPULATION OF TEMPOROMANDIBULAR JOINT(S) (TMJ), THERAPEUTIC, REQUIRING AN ANESTHESIA SERVICE (IE, GENERAL OR MONITORED ANESTHESIA CARE)	NON-COVERED	CMP95029	NON-COVERED	Medicare Benefit Chapter Manual 15 Section 150.1	
22505	MANIPULATION OF SPINE REQUIRING ANESTHESIA, ANY REGION	NON-COVERED	CMP95029	PRIOR AUTHORIZATION NOT REQUIRED		
22526	PERQ INTRDSCL ELECTROTHRM ANNULOPLASTY 1 LEVEL	NON-COVERED	MCG A-0217 (CMP202407)	NON-COVERED	CMS	
22527	PERQ INTRDSCL ELECTROTHRM ANNULOPLASTY ADDL LVL	NON-COVERED	MCG A-0217 (CMP202407)	NON-COVERED	CMS	
23700	MNPJ W/ANES SHOULDER JT APPL FIXATION APPARATUS	NON-COVERED	CMP95029	PRIOR AUTHORIZATION NOT REQUIRED		
24300	MANIPULATION ELBOW UNDER ANESTHESIA	NON-COVERED	CMP95029	PRIOR AUTHORIZATION NOT REQUIRED		
25259	MANIPULATION WRIST UNDER ANESTHESIA	NON-COVERED	CMP95029	PRIOR AUTHORIZATION NOT REQUIRED		
27275	MANIPULATION, HIP JOINT, REQUIRING GENERAL ANESTHESIA	NON-COVERED	CMP95029	NON-COVERED	CMP95029	
27278	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	NON-COVERED	CMP2019-G	PRIOR AUTHORIZATION REQUIRED-FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
27570	MANIPULATION KNEE JOINT UNDER GENERAL ANESTHESIA	NON-COVERED	CMP95029	PRIOR AUTHORIZATION NOT REQUIRED		
27860	MANIPULATION ANKLE UNDER GENERAL ANESTHESIA	NON-COVERED	CMP95029	PRIOR AUTHORIZATION NOT REQUIRED		
30468	REPAIR OF NASAL VALVE COLLAPSE WITH SUBCUTANEOUS/SUBMUCOSAL LATERAL WALL IMPLANT(S)	NON-COVERED	CMP200509	PRIOR AUTHORIZATION NOT REQUIRED		

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30469	REPAIR OF NASAL VALVE COLLAPSE WITH LOW ENERGY, TEMPERATURE-CONTROLLED (IE, RADIOFREQUENCY) SUBCUTANEOUS/SUBMUCOSAL REMODELING	NON-COVERED	CMP200509	PRIOR AUTHORIZATION NOT REQUIRED		
31242	NASAL/SINUS ENDOSCOPY, SURGICAL; WITH DESTRUCTION BY RADIOFREQUENCY ABLATION, POSTERIOR NASAL NERVE	NON-COVERED	CMP202016	PRIOR AUTHORIZATION NOT REQUIRED		
31243	NASAL/SINUS ENDOSCOPY, SURGICAL; WITH DESTRUCTION BY CRYOABLATION, POSTERIOR NASAL NERVE	NON-COVERED	CMP202016	PRIOR AUTHORIZATION NOT REQUIRED		
37241	VASCULAR EMBOLIZATION OR OCCLUSION, INCLUSIVE OF ALL RADIOLOGICAL SUPERVISION AND INTERPRETATION, INTRAPROCEDURAL ROADMAPPING, AND IMAGING GUIDANCE NECESSARY TO COMPLETE THE INTERVENTION; VENOUS, OTHER THAN HEMORRHAGE (EG, CONGENITAL OR ACQUIRED VENOUS MALFORMATIONS, VENOUS AND CAPILLARY HEMANGIOMAS, VARICES, VARICOCELES)	NON-COVERED FOR CERTAIN INDICATIONS (see note)	CMP201913, MCG A-0567 (CMP202406)	PRIOR AUTHORIZATION REQUIRED-FOLLOW MEDICARE COVERAGE CRITERIA	CMS	IE for ovarian vein, internal iliac vein, or prostatic artery embolization
37242	VASCULAR EMBOLIZATION OR OCCLUSION, INCLUSIVE OF ALL RADIOLOGICAL SUPERVISION AND INTERPRETATION, INTRAPROCEDURAL ROADMAPPING, AND IMAGING GUIDANCE NECESSARY TO COMPLETE THE INTERVENTION; ARTERIAL, OTHER THAN HEMORRHAGE OR TUMOR (EG, CONGENITAL OR ACQUIRED ARTERIAL MALFORMATIONS, ARTERIOVENOUS MALFORMATIONS, ARTERIOVENOUS FISTULAS, ANEURYSMS, PSEUDOANEURYSMS)	NON-COVERED FOR CERTAIN INDICATIONS (see note)	CMP201913	NON-COVERED FOR CERTAIN INDICATIONS (see note)	CMS	Prostatic artery embolization is investigational/experimental
37243	VASCULAR EMBOLIZATION OR OCCLUSION, INCLUSIVE OF ALL RADIOLOGICAL SUPERVISION AND INTERPRETATION, INTRAPROCEDURAL ROADMAPPING, AND IMAGING GUIDANCE NECESSARY TO COMPLETE THE INTERVENTION; FOR TUMORS, ORGAN ISCHEMIA, OR INFARCTION	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES (See Notes)	MCG	PRIOR AUTHORIZATION REQUIRED-FOLLOW MEDICARE COVERAGE CRITERIA (See Notes)	CMS	PRIOR APPROVAL IS ONLY REQUIRED FOR UTERINE ARTERY EMBOLIZATION (UAE) PROSTATIC ARTERY EMBOLIZATION IS INVESTIGATIONAL/ EXPERIMENTAL
46607	ANOSCOPY DX W/HRA &CHEM AGNTS ENHANCEMENT W/BX	PRIOR AUTHORIZATION NOT REQUIRED	None	NON-COVERED FOR CERTAIN INDICATIONS (see note)	CMS	
61885	INSJ/RPLCMT CRANIAL NEUROSTIM PULSE GENERATOR	NON-COVERED	MCG B-821-T (CMP202406)	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
62263	PERCUTANEOUS LYSIS OF EPIDURAL ADHESIONS USING SOLUTION INJECTION (EG, HYPERTONIC, SALINE, ENZYME) OR MECHANICAL MEANS (EG, CATHETER) INCLUDING RADIOLOGIC LOCALIZATION (INCLUDES CONTRAST WHEN ADMINISTERED), MULTIPLE ADHESIOLYSIS SESSIONS; 2 OR MORE DAYS	NON-COVERED	CMP200522	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP200522	
75894	TRANSCATHETER THERAPY, EMBOLIZATION, ANY METHOD, RADIOLOGICAL SUPERVISION AND INTERPRETATION	NON-COVERED	MCG A-0567 (CMP202406)	NON-COVERED FOR CERTAIN INDICATIONS (see note)	MCG A-0567 (CMP202406)	
75898	ANGIOGRAPHY THROUGH EXISTING CATHETER FOR FOLLOW-UP STUDY FOR TRANSCATHETER THERAPY, EMBOLIZATION OR INFUSION, OTHER THAN FOR THROMBOLYSIS	NON-COVERED	MCG A-0567 (CMP202406)	NON-COVERED FOR CERTAIN INDICATIONS (see note)	MCG A-0567 (CMP202406)	
76981	ULTRASOUND, ELASTOGRAPHY; PARENCHYMA (EG, ORGAN)	NON-COVERED	CMP201935	PRIOR AUTHORIZATION NOT REQUIRED		
76982	ULTRASOUND, ELASTOGRAPHY; FIRST TARGET LESION	NON-COVERED	CMP201935	PRIOR AUTHORIZATION NOT REQUIRED		
76983	ULTRASOUND, ELASTOGRAPHY; EACH ADDITIONAL TARGET LESION (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)	NON-COVERED	CMP201935	PRIOR AUTHORIZATION NOT REQUIRED		
77089	TBS DXA/OTHER IMG CALCULATION W/I&R FX RISK	NON-COVERED	CMP94022	NON-COVERED	CMP94022	
77090	TBS TECHL PREP&TRANSMIS DATA ALYS PFRMD ELSEWHR	NON-COVERED	CMP94022	NON-COVERED	CMP94022	
77092	TBS INTERPRETATION & REPORT FX RISK BY OTHER QHP	NON-COVERED	CMP94022	NON-COVERED	CMP94022	
78350	BONE DENSITY 1/> SITES 1 PHOTON ABSORPTIOMETRY	NON-COVERED	CMP94022	PRIOR AUTHORIZATION NOT REQUIRED		
78351	BONE DENSTY 1/> SITES DUAL PHOTON ABSORPTIOMETR	NON-COVERED	CMP94022	PRIOR AUTHORIZATION NOT REQUIRED		
84112	EVALUATION OF CERVICOVAGINAL FLUID FOR SPECIFIC AMNIOTIC FLUID PROTEIN(S) (EG, PLACENTAL ALPHA MICROGLOBULIN-1 (PAMG-1), PLACENTAL PROTEIN 12 (PP12), ALPHA-FETOPROTEIN), QUALITATIVE, EACH SPECIMEN	NON-COVERED	CMP201535	NON-COVERED	CMP201535	
89344	STORAGE (PER YEAR); REPRODUCTIVE TISSUE, TESTICULAR/OVARIAN	NON-COVERED FOR CERTAIN INDICATIONS (see note)	CMP202302	PRIOR AUTHORIZATION NOT REQUIRED		Storage of testicular/ovarian tissue is IE
91112	GASTROINTESTINAL TRANSITAND PRESSURE MEASUREMENT, STOMACH THROUGH COLON, WIRELESS CAPSULE, WITH INTERPRETATION AND REPORT	NON-COVERED	CMP2011-C	NON-COVERED	CMP2011-C	
92517	CERVICAL VEMP TESTING W/I&R	NON-COVERED	CMP94007	PRIOR AUTHORIZATION NOT REQUIRED		
95060	OPHTHALMIC MUCOUS MEMBRANE TESTS	NON-COVERED	CMP99005	NON-COVERED	CMP99005	
95065	DIRECT NASAL MUCOUS MEMBRANE TEST	NON-COVERED	CMP99005	NON-COVERED	CMP99005	
96000	COMPREHENSIVE COMPUTER-BASED MOTION ANALYSIS BY VIDEO-TAPING AND 3D KINEMATICS	NON-COVERED	MCG A-0720 (CMP202407)	NON-COVERED	MCG A-0720 (CMP202407)	
96001	COMPREHENSIVE COMPUTER-BASED MOTION ANALYSIS BY VIDEO-TAPING AND 3D KINEMATICS; WITH DYNAMIC PLANTAR PRESSURE MEASUREMENTS DURING WALKING	NON-COVERED	MCG A-0720 (CMP202407)	NON-COVERED	MCG A-0720 (CMP202407)	
96002	DYNAMIC SURFACE ELECTROMYOGRAPHY, DURING WALKING OR OTHER FUNCTIONAL ACTIVITIES, 1-12 MUSCLES	NON-COVERED	MCG A-0720 (CMP202407)	NON-COVERED	MCG A-0720 (CMP202407)	

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96004	REVIEW AND INTERPRETATION BY PHYSICIAN OR OTHER QUALIFIED HEALTH CARE PROFESSIONAL OF COMPREHENSIVE COMPUTER-BASED MOTION ANALYSIS, DYNAMIC PLANTAR PRESSURE MEASUREMENTS, DYNAMIC SURFACE ELECTROMYOGRAPHY DURING WALKING OR OTHER FUNCTIONAL ACTIVITIES, AND DYNAMIC FINE WIRE ELECTROMYOGRAPHY, WITH WRITTEN REPORT	NON-COVERED	MCG A-0720 (CMP202407)	NON-COVERED	MCG A-0720 (CMP202407)	
96931	REFLECTANCE CONFOCAL MICROSCOPY (RCM) FOR CELLULAR AND SUB-CELLULAR IMAGING OF SKIN; IMAGE ACQUISITION AND INTERPRETATION AND REPORT, FIRST LESION	NON-COVERED	CMP200903	PRIOR AUTHORIZATION NOT REQUIRED		
96932	REFLECTANCE CONFOCAL MICROSCOPY (RCM) FOR CELLULAR AND SUB-CELLULAR IMAGING OF SKIN; IMAGE ACQUISITION ONLY, FIRST LESION	NON-COVERED	CMP200903	PRIOR AUTHORIZATION NOT REQUIRED		
96933	REFLECTANCE CONFOCAL MICROSCOPY (RCM) FOR CELLULAR AND SUB-CELLULAR IMAGING OF SKIN; INTERPRETATION AND REPORT ONLY, FIRST LESION	NON-COVERED	CMP200903	PRIOR AUTHORIZATION NOT REQUIRED		
96934	REFLECTANCE CONFOCAL MICROSCOPY (RCM) FOR CELLULAR AND SUB-CELLULAR IMAGING OF SKIN; IMAGE ACQUISITION AND INTERPRETATION AND REPORT, EACH ADDITIONAL LESION (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)	NON-COVERED	CMP200903	PRIOR AUTHORIZATION NOT REQUIRED		
96935	REFLECTANCE CONFOCAL MICROSCOPY (RCM) FOR CELLULAR AND SUB-CELLULAR IMAGING OF SKIN; IMAGE ACQUISITION ONLY, EACH ADDITIONAL LESION (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)	NON-COVERED	CMP200903	PRIOR AUTHORIZATION NOT REQUIRED		
96936	REFLECTANCE CONFOCAL MICROSCOPY (RCM) FOR CELLULAR AND SUB-CELLULAR IMAGING OF SKIN; INTERPRETATION AND REPORT ONLY, EACH ADDITIONAL LESION (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)	NON-COVERED	CMP200903	PRIOR AUTHORIZATION NOT REQUIRED		
97014	APPL MODALITY 1/> AREAS ELEC STIMJ UNATTENDED	NON-COVERED	CMP2003-C	PRIOR AUTHORIZATION NOT REQUIRED		
97032	APPL MODALITY 1+ AREAS ESTIM EA 15 MIN	NON-COVERED	CMP2003-C	PRIOR AUTHORIZATION NOT REQUIRED		
97039	UNLISTED MODALITY SPEC TYPE&TIME CONSTANT ATTN	NON-COVERED	CMP2003-C	NON-COVERED FOR CERTAIN INDICATIONS (see note)	CMS	
0054T	COMPUTER-ASSISTED MUSCULOSKELETAL SURGICAL NAVIGATIONAL ORTHOPEDIC PROCEDURE, WITH IMAGE-GUIDANCE BASED ON FLUOROSCOPIC IMAGES (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)	NON-COVERED	CMP2019-D	NON-COVERED	CMP2019-D	
0055T	CPTR-ASST MUSCSKEL NAVIGJ ORTHO CT/MRI	NON-COVERED	CMP2019-D	NON-COVERED	CMP2019-D	
0232T	INJECTION(S), PLATELET RICH PLASMA, ANY SITE, INCLUDING IMAGE GUIDANCE, HARVESTING AND PREPARATION WHEN PERFORMED	NON-COVERED	MCG A-0630 (CMP202407)	PRIOR AUTHORIZATION NOT REQUIRED		
0528T	PROGRAMMING DEVICE EVALUATION (IN PERSON) OF INTRACARDIAC ISCHEMIA MONITORING SYSTEM WITH ITERATIVE ADJUSTMENT OF PROGRAMMED VALUES, WITH ANALYSIS, REVIEW, AND REPORT	NON-COVERED	CMP202406	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP202406	
0529T	INTERROGATION DEVICE EVALUATION (IN PERSON) OF INTRACARDIAC ISCHEMIA MONITORING SYSTEM WITH ANALYSIS, REVIEW, AND REPORT	NON-COVERED	CMP202406	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP202406	
0554T	BONE STRENGTH AND FRACTURE RISK USING FINITE ELEMENT ANALYSIS OF FUNCTIONAL DATA, AND BONE-MINERAL DENSITY, UTILIZING DATA FROM A COMPUTED TOMOGRAPHY SCAN; RETRIEVAL AND TRANSMISSION OF THE SCAN DATA, ASSESSMENT OF BONE STRENGTH AND FRACTURE RISK AND BONE MINERAL DENSITY, INTERPRETATION AND REPORT	NON-COVERED	CMP94022, CMP202406	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0556T	BONE STRENGTH AND FRACTURE RISK USING FINITE ELEMENT ANALYSIS OF FUNCTIONAL DATA, AND BONE-MINERAL DENSITY, UTILIZING DATA FROM A COMPUTED TOMOGRAPHY SCAN; ASSESSMENT OF BONE STRENGTH AND FRACTURE RISK AND BONE MINERAL DENSITY	NON-COVERED	CMP94022, CMP202406	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0557T	BONE STRENGTH AND FRACTURE RISK USING FINITE ELEMENT ANALYSIS OF FUNCTIONAL DATA, AND BONE-MINERAL DENSITY, UTILIZING DATA FROM A COMPUTED TOMOGRAPHY SCAN; INTERPRETATION AND REPORT	NON-COVERED	CMP94022, CMP202406	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0578T	INTERROGATION DEVICE EVALUATION(S) (REMOTE), UP TO 90 DAYS, SUBSTERNAL LEAD IMPLANTABLE CARDIOVERTER-DEFIBRILLATOR SYSTEM WITH INTERIM ANALYSIS, REVIEW(S) AND REPORT(S) BY A PHYSICIAN OR OTHER QUALIFIED HEALTH CARE PROFESSIONAL	NON-COVERED	CMP202406	PRIOR AUTHORIZATION NOT REQUIRED		
0586T	ISLET CELL TRANSPLANT, INCLUDES PORTAL VEIN CATHETERIZATION AND INFUSION, INCLUDING ALL IMAGING, INCLUDING GUIDANCE, AND RADIOLOGICAL SUPERVISION AND INTERPRETATION, WHEN PERFORMED; OPEN	NON-COVERED	CMP201102, CMP202406	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
0865T	QUAN MRI ALYS BRAIN W/O DIAGNOSTIC MRI SAME SESS	NON-COVERED	CMP202406	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP 202406	

Codes	Code Description	Medical Mutual Commercial	Medical Mutual Commercial Criteria	Medicare Advantage	Medicare Advantage Criteria	Details/Notes
0866T	QUAN MRI ALYS BRAIN WITH DIAGNOSTIC MRI	NON-COVERED	CMP202406	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMP 202406	
A2011	Supra sdrm, per square centimeter	NON-COVERED	CMP202033	PRIOR AUTHORIZATION NOT REQUIRED		
A2012	Suprathel, per square centimeter	NON-COVERED	CMP202033	PRIOR AUTHORIZATION NOT REQUIRED		
A2013	Innovamatrix fs, per square centimeter	NON-COVERED	CMP202033	PRIOR AUTHORIZATION NOT REQUIRED		
A2014	Omeza collagen matrix, per 100 mg	NON-COVERED	CMP202033	PRIOR AUTHORIZATION NOT REQUIRED		
A2015	Phoenix wound matrix, per square centimeter	NON-COVERED	CMP202033	PRIOR AUTHORIZATION NOT REQUIRED		
A2016	Permeaderm b, per square centimeter	NON-COVERED	CMP202033	PRIOR AUTHORIZATION NOT REQUIRED		
A2017	Permeaderm glove, each	NON-COVERED	CMP202033	PRIOR AUTHORIZATION NOT REQUIRED		
A2018	Permeaderm c, per square centimeter	NON-COVERED	CMP202033	PRIOR AUTHORIZATION NOT REQUIRED		
A2019	Kerecis omega3 marigen shield, per square centimeter	NON-COVERED	CMP202033	PRIOR AUTHORIZATION NOT REQUIRED		
A2021	Neomatrix, per square centimeter	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
A2022	INNOVABURN OR INNOVAMATRIX XL, PER SQUARE CENTIMETER	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
A2023	INNOVAMATRIX PD, 1 MG	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
A2024	RESOLVE MATRIX, PER SQUARE CENTIMETER	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
A2025	MIRO3D, PER CUBIC CENTIMETER	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
A2027	Matriderm, per square centimeter	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
A2028	Micromatrix flex, per mg	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
A2029	Mirotract wound matrix sheet, per cubic centimeter	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
A2036	COHEALYX COLLAGEN DERMAL MATRIX, PER SQ CM	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
A2037	G4DERM PLUS, PER ML	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
A2038	MARIGEN PACTO PER SQ CM	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
A2039	INNOVAMATRIX FD, PER SQ CM	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
A4540	"Distal transcutaneous electrical nerve stimulator, stimulates peripheral nerves of the upper arm"	NON-COVERED	CMP201004	PRIOR AUTHORIZATION NOT REQUIRED		
A4541	Monthly supplies for use of device coded at e0733	NON-COVERED	CMP201004	PRIOR AUTHORIZATION NOT REQUIRED		
A4542	Supplies and accessories for external upper limb tremor stimulator of the peripheral nerves of the wrist	NON-COVERED	CMP202202	PRIOR AUTHORIZATION NOT REQUIRED		
A4543	Supplies for transcutaneous electrical nerve stimulator, for nerves in the auricular region, per month	NON-COVERED	CMP201004	PRIOR AUTHORIZATION NOT REQUIRED		
A4544	Electrode for external lower extremity nerve stimulator for restless legs syndrome	NON-COVERED	CMP201004	PRIOR AUTHORIZATION NOT REQUIRED		
A4560	NEUROMUSCULAR ELECTRICAL STIMULATOR (NMES), DISPOSABLE, REPLACEMENT ONLY	NON-COVERED	CMP200604	PRIOR AUTHORIZATION NOT REQUIRED		
A4593	NEUROMODULATION STIMULATOR SYSTEM, ADJUNCT TO REHABILITATION THERAPY REGIME, CONTROLLER	NON-COVERED	CMP200604	PRIOR AUTHORIZATION NOT REQUIRED		
A4594	NEUROMODULATION STIMULATOR SYSTEM, ADJUNCT TO REHABILITATION THERAPY REGIME, MOUTHPIECE, EACH	NON-COVERED	CMP200604	PRIOR AUTHORIZATION NOT REQUIRED		
A4596	CRANIAL ELECTROTHERAPY STIMULATION (CES) SYSTEM SUPPLIES AND ACCESSORIES, PER MONTH	NON-COVERED	CMP201004	PRIOR AUTHORIZATION NOT REQUIRED		
A4638	REPLACEMENT BATTERY FOR PATIENT-OWNED EAR PULSE GENERATOR, EACH	NON-COVERED	MCG A-0978 (CMP202407)	NON-COVERED	MCG A-0978 (CMP202407)	
A4639	Replacement pad for infrared heating pad system, each	NON-COVERED	CMP202206	NON-COVERED	CMS	
C9352	Microporous collagen implantable tube (neuragen nerve guide), per centimeter length	NON-COVERED	CMP2019-F	PRIOR AUTHORIZATION NOT REQUIRED		
C9353	Microporous collagen implantable slit tube (neurawrap nerve protector), per centimeter length	NON-COVERED	CMP2019-F	PRIOR AUTHORIZATION NOT REQUIRED		
C9355	Collagen nerve cuff (neuromatrix), per 0.5 centimeter length	NON-COVERED	CMP2019-F	PRIOR AUTHORIZATION NOT REQUIRED		
C9361	COLLAGEN MATRIX NERVE WRAP (NEUROMEND COLLAGEN NERVE WRAP), PER 0.5 CM LENGTH	NON-COVERED	CMP2019-F, CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
C9781	ARTHROSCOPY, SHOULDER, SURGICAL; WITH IMPLANTATION OF SUBACROMIAL SPACER (E.G., BALLOON), INCLUDES DEBRIDEMENT (E.G., LIMITED OR EXTENSIVE), SUBACROMIAL DECOMPRESSION, ACROMIOPLASTY, AND BICEPS TENODESIS WHEN PERFORMED	NON-COVERED	CMP202304	PRIOR AUTHORIZATION NOT REQUIRED		
E0221	Infrared heating pad system	NON-COVERED	CMP202206	PRIOR AUTHORIZATION NOT REQUIRED		
E0469	Lung expansion airway clearance, continuous high frequency oscillation, and nebulization device	NON-COVERED	CMP200508	PRIOR AUTHORIZATION NOT REQUIRED		
E0481	INTRAPULMONARY PERCUSSIVE VENTILATION SYSTEM AND RELATED ACCESSORIES	NON-COVERED	MCG A-0727 (CMP202406)	PRIOR AUTHORIZATION NOT REQUIRED		
E0490	POWER SOURCE AND CONTROL ELECTRONICS UNIT FOR ORAL DEVICE/APPLIANCE FOR NEUROMUSCULAR ELECTRICAL STIMULATION OF THE TONGUE MUSCLE, CONTROLLED BY HARDWARE REMOTE	NON-COVERED	CMP2014-A	PRIOR AUTHORIZATION NOT REQUIRED		

Codes	Code Description	Medical Mutual Commercial	Medical Mutual Commercial Criteria	Medicare Advantage	Medicare Advantage Criteria	Details/Notes
E0491	ORAL DEVICE/APPLIANCE FOR NEUROMUSCULAR ELECTRICAL STIMULATION OF THE TONGUE MUSCLE, USED IN CONJUNCTION WITH THE POWER SOURCE AND CONTROL ELECTRONICS UNIT, CONTROLLED BY HARDWARE REMOTE, 90-DAY SUPPLY	NON-COVERED	CMP2014-A	PRIOR AUTHORIZATION NOT REQUIRED		
E0492	"Power source and control electronics unit for oral device/appliance for neuromuscular electrical stimulation of the tongue muscle, controlled by phone application"	NON-COVERED	CMP2014-A	PRIOR AUTHORIZATION NOT REQUIRED		
E0493	"Oral device/appliance for neuromuscular electrical stimulation of the tongue muscle, used in conjunction with the power source and control electronics unit, controlled by phone application, 90-day supply"	NON-COVERED	CMP2014-A	PRIOR AUTHORIZATION NOT REQUIRED		
E0530	"Electronic positional obstructive sleep apnea treatment, with sensor, includes all components and accessories, any type"	NON-COVERED	CMP2014-A	PRIOR AUTHORIZATION NOT REQUIRED		
E0650	PNEUMATIC COMPRESSOR, NON\SEGMENTAL HOME MODEL (MAY BE COVERED UNDER SOME NATIONAL CONTRACTS)	NON-COVERED	MCG A-0340	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
E0651	PNEUMATIC COMPRESSOR, SEGMENTAL HOME MODEL WITHOUT CALIBRATED GRADIENT PRESSURE (MAY BE COVERED ON SOME NATIONAL CONTRACTS)	NON-COVERED	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
E0655	NON\SEGMENTAL PNEUMATIC APPLIANCE FOR USE WITH PNEUMATIC COMPRESSOR, HALF ARM (MAY BE COVERED UNDER SOME NATIONAL CONTRACTS)	NON-COVERED	MCG A-0340	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
E0656	SEGMENTAL PNEUMATIC APPLICANCE FOR USE WITH PNEUMATIC COMPRESSOR, TRUNK	NON-COVERED	CMP201621	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
E0657	SEGMENTAL PNEUMATIC APPLIANCE FOR USE WITH PNEUMATIC COMPRESSOR, CHEST	NON-COVERED	CMP201621	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
E0658	SEGMENTAL PNEUMATIC APPLIANCE FOR USE WITH PNEUMATIC COMPRESSOR, INTEGRATED, 2 FULL ARMS AND CHEST	NON-COVERED	CMP201621	PRIOR AUTHORIZATION NOT REQUIRED		
E0659	SEGMENTAL PNEUMATIC APPLIANCE FOR USE WITH PNEUMATIC COMPRESSOR, INTEGRATED, HEAD, NECK AND CHEST	NON-COVERED	CMP201621	PRIOR AUTHORIZATION NOT REQUIRED		
E0660	NON\SEGMENTAL PNEUMATIC APPLIANCE FOR USE WITH PNEUMATIC COMPRESSOR, FULL LEG (MAY BE COVERED UNDER SOME NATIONAL CONTRACTS)	NON-COVERED	MCG A-0340	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
E0665	NON\SEGMENTAL PNEUMATIC APPLIANCE FOR USE WITH PNEUMATIC COMPRESSOR, FULL ARM (MAY BE COVERED UNDER SOME NATIONAL CONTRACTS)	NON-COVERED	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
E0666	NON\SEGMENTAL PNEUMATIC APPLIANCE FOR USE WITH PNEUMATIC COMPRESSOR, HALF LEG (MAY BE COVERED UNDER SOME NATIONAL CONTRACTS)	NON-COVERED	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
E0667	SEGMENTAL PNEUMATIC APPLIANCE FOR USE WITH PNEUMATIC COMPRESSOR, FULL LEG (MAY BE COVERED UNDER SOME NATIONAL CONTRACTS)	NON-COVERED	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
E0668	SEGMENTAL PNEUMATIC APPLIANCE FOR USE WITH PNEUMATIC COMPRESSOR, FULL ARM (MAY BE COVERED UNDER SOME NATIONAL CONTRACTS)	NON-COVERED	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
E0669	SEGMENTAL PNEUMATIC APPLIANCE FOR USE WITH PNEUMATIC COMPRESSOR, HALF LEG	NON-COVERED	MCG A-0340	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
E0670	SEGMENTAL PNEUMATIC APPLIANCE FOR USE WITH PNEUMATIC COMPRESSOR, INTEGRATED, 2 FULL LEGS AND TRUNK	NON-COVERED	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
E0671	SEGMENTAL GRADIENT PRESSURE PNEUMATIC APPLIANCE, FULL LEG	NON-COVERED	MCG	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
E0672	SEGMENTAL GRADIENT PRESSURE PNEUMATIC APPLIANCE, FULL ARM	NON-COVERED	MCG A-0340	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
E0673	SEGMENTAL GRADIENT PRESSURE PNEUMATIC APPLIANCE, HALF LEG	NON-COVERED	MCG A-0340	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
E0676	INTERMITTENT LIMB COMPRESSION DEVICE (INCLUDES ALL ACCESSORIES), NOT OTHERWISE SPECIFIED	NON-COVERED	MCG A-0340	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
E0677	NON-PNEUMATIC SEQUENTIAL COMPRESSION GARMENT, TRUNK	NON-COVERED	CMP202203	PRIOR AUTHORIZATION NOT REQUIRED		
E0678	NONPNEUMATIC SEQUENTIAL COMPRESSION GARMENT, FULL LEG	NON-COVERED	CMP202203	PRIOR AUTHORIZATION NOT REQUIRED		
E0679	"Non-pneumatic sequential compression garment, half leg"	NON-COVERED	CMP202203	PRIOR AUTHORIZATION NOT REQUIRED		
E0680	Non-pneumatic compression controller with sequential calibrated gradient pressure	NON-COVERED	CMP202203	PRIOR AUTHORIZATION NOT REQUIRED		
E0681	Non-pneumatic compression controller without calibrated gradient pressure	NON-COVERED	CMP202203	PRIOR AUTHORIZATION NOT REQUIRED		
E0682	"Non-pneumatic sequential compression garment, full arm"	NON-COVERED	CMP202203	PRIOR AUTHORIZATION NOT REQUIRED		
E0683	Non-pneumatic, non-sequential, peristaltic wave compression pump	NON-COVERED	CMP202203	PRIOR AUTHORIZATION NOT REQUIRED		

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E0715	Intravaginal device intended to strengthen pelvic floor muscles during kegel exercises	NON-COVERED	CMP200520	PRIOR AUTHORIZATION NOT REQUIRED		
E0716	Supplies and accessories for intravaginal device intended to strengthen pelvic floor muscles during kegel exercises	NON-COVERED	CMP200520	PRIOR AUTHORIZATION NOT REQUIRED		
E0721	Transcutaneous electrical nerve stimulator for nerves in the auricular region	NON-COVERED	CMP201004	PRIOR AUTHORIZATION NOT REQUIRED		
E0732	"Cranial electrotherapy stimulation (ces) system, any type"	NON-COVERED	CMP201004	PRIOR AUTHORIZATION NOT REQUIRED		
E0733	Transcutaneous electrical nerve stimulator for electrical stimulation of the trigeminal nerve	NON-COVERED	CMP201004	PRIOR AUTHORIZATION NOT REQUIRED		
E0734	External upper limb tremor stimulator of the peripheral nerves of the wrist	NON-COVERED	CMP202202	PRIOR AUTHORIZATION NOT REQUIRED		
E0735	Non-invasive vagus nerve stimulator	NON-COVERED	MCG A-0998 (CMP202406)	PRIOR AUTHORIZATION NOT REQUIRED		
E0738	UPPER EXTREMITY REHABILITATION SYSTEM PROVIDING ACTIVE ASSISTANCE TO FACILITATE MUSCLE RE-EDUCATION, INCLUDES MICROPROCESSOR, ALL COMPONENTS AND ACCESSORIES	NON-COVERED	CMP2016-B	NON-COVERED		
E0739	REHAB SYSTEM WITH INTERACTIVE INTERFACE PROVIDING ACTIVE ASSISTANCE IN REHABILITATION THERAPY, INCLUDES ALL COMPONENTS AND ACCESSORIES, MOTORS, MICROPROCESSORS, SENSORS	NON-COVERED	CMP2016-B	NON-COVERED		
E0743	External lower extremity nerve stimulator for restless legs syndrome, each	NON-COVERED	CMP201004	PRIOR AUTHORIZATION NOT REQUIRED		
E0744	Neuromuscular stimulator for scoliosis	NON-COVERED	CMP200604	PRIOR AUTHORIZATION NOT REQUIRED		
E0745	Neuromuscular stimulator, electronic shock unit	NON-COVERED	CMP2003-C	PRIOR AUTHORIZATION NOT REQUIRED		
E0762	TRANSCUTANEOUS ELECTRICAL JOINT STIMULATION DEVICE SYSTEM, INCLUDES ALL ACCESSORIES	NON-COVERED	CMP201004	NON-COVERED	CMS	
E0769	ELECTRICAL STIMULATION OR ELECTROMAGNETIC WOUND TREATMENT DEVICE, NOT OTHERWISE CLASSIFIED	NON-COVERED	MCG A-0242 (CMP202406)	NON-COVERED	CMS	
E0770	FUNCTIONAL ELECTRICAL STIMULATOR, TRANSCUTANEOUS STIMULATION OF NERVE AND/OR MUSCLE GROUPS, ANY TYPE, COMPLETE SYSTEM, NOT OTHERWISE SPECIFIED	NON-COVERED	CMP200604	PRIOR AUTHORIZATION REQUIRED - MILLIMAN CARE GUIDELINES	MCG	
E0935	Continuous passive motion exercise device for use on knee only	NON-COVERED	MCG A-0335 (CMP202407)	PRIOR AUTHORIZATION NOT REQUIRED		
E0936	Continuous passive motion exercise device for use other than knee	NON-COVERED	MCG A-0335 (CMP202407)	PRIOR AUTHORIZATION NOT REQUIRED		
E2120	PULSE GENERATOR SYSTEM FOR TYMPANIC TREATMENT OF INNER EAR ENDOLYMPHATIC FLUID	NON-COVERED	MCG A-0978 (CMP202407)	NON-COVERED	MCG A-0978 (CMP202407)	
G0329	ELECTROMAGNETIC THERAPY, TO ONE OR MORE AREAS FOR CHRONIC STAGE III AND STAGE IV PRESSURE ULCERS, ARTERIAL ULCERS, DIABETIC ULCERS AND VENOUS STASIS ULCERS NOT DEMONSTRATING MEASURABLE SIGNS OF HEALING AFTER 30 DAYS OF CONVENTIONAL CARE AS PART OF A THERAPY PLAN OF CARE	NON-COVERED	MCG A-0242 (CMP202406)	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
G0428	Collagen meniscus implant procedure for filling meniscal defects (e.g., cmi, collagen scaffold, menaflex)	NON-COVERED	CMP200714	PRIOR AUTHORIZATION NOT REQUIRED		
G0460	AUTOLOGOUS PLATELET RICH PLASMA (PRP) OR OTHER BLOOD-DERIVED PRODUCT FOR NONDIABETIC CHRONIC WOUNDS/ULCERS (INCLUDES, AS APPLICABLE: ADMINISTRATION, DRESSINGS, PHLEBOTOMY, CENTRIFUGATION OR MIXING, AND ALL OTHER PREPARATORY PROCEDURES, PER TREATMENT)	NON-COVERED	MCG A-0630 (CMP202407)	PRIOR AUTHORIZATION NOT REQUIRED		
G0465	AUTOLOGOUS PLATELET RICH PLASMA (PRP) OR OTHER BLOOD-DERIVED PRODUCT FOR DIABETIC CHRONIC WOUNDS/ULCERS, USING AN FDA-CLEARED DEVICE FOR THIS INDICATION, (INCLUDES, AS APPLICABLE: ADMINISTRATION, DRESSINGS, PHLEBOTOMY, CENTRIFUGATION OR MIXING, AND ALL OTHER PREPARATORY PROCEDURES, PER TREATMENT)	NON-COVERED	MCG A-0630 (CMP202407)	NON-COVERED	CMS	
L3904	WRIST HAND FINGER ORTHOSIS, EXTERNAL POWERED, ELECTRIC, CUSTOM FABRICATED	NON-COVERED	CMP2016-B	NON-COVERED	CMP 2016-B	
L8605	INJECTABLE BULKING AGENT, DEXTRANOMER/HYALURONIC ACID COPOLYMER IMPLANT, ANAL CANAL, 1 ML, INCLUDES SHIPPING AND NECESSARY SUPPLIES	NON-COVERED	CMP201942	PRIOR AUTHORIZATION NOT REQUIRED		
L8680	IMPLANTABLE NEUROSTIMULATOR ELECTRODE, EACH	NON-COVERED	CMP201004, MCG B-821-T (CMP202406)	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
L8682	IMPLANTABLE NEUROSTIMULATOR RADIOFREQUENCY RECEIVER	NON-COVERED	CMP200602, CMP201004	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
L8683	RADIOFREQUENCY TRANSMITTER (EXTERNAL) FOR USE WITH IMPLANTABLE NEUROSTIMULATOR RADIOFREQUENCY RECEIVER	NON-COVERED	CMP200602, CMP201004	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
L8685	IMPLANTABLE NEUROSTIMULATOR PULSE GENERATOR, SINGLE ARRAY, RECHARGEABLE, INCLUDES EXTENSION	NON-COVERED	CMP200602, CMP201004, MCG B-821-T (CMP202406)	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	

Codes	Code Description	Medical Mutual Commercial	Medical Mutual Commercial Criteria	Medicare Advantage	Medicare Advantage Criteria	Details/Notes
L8686	IMPLANTABLE NEUROSTIMULATOR PULSE GENERATOR, SINGLE ARRAY, NON\RECHARGEABLE, INCLUDES EXTENSION	NON-COVERED	CMP200602, CMP201004, MCG B-821-T (CMP202406)	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
L8687	IMPLANTABLE NEUROSTIMULATOR PULSE GENERATOR, DUAL ARRAY, RECHARGEABLE, INCLUDES EXTENSION	NON-COVERED	CMP200602, CMP201004, MCG B-821-T (CMP202406)	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
L8688	IMPLANTABLE NEUROSTIMULATOR PULSE GENERATOR, DUAL ARRAY, NON\RECHARGEABLE, INCLUDES EXTENSION	NON-COVERED	CMP200602, CMP201914, CMP201004, MCG B-821-T (CMP202406)	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
L8689	EXTERNAL RECHARGING SYSTEM FOR BATTERY (INTERNAL) FOR USE WITH IMPLANTABLE NEUROSTIMULATOR, REPLACEMENT ONLY	NON-COVERED	CMP200602, CMP201004	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
L8695	EXTERNAL RECHARGING SYSTEM FOR BATTERY (EXTERNAL) FOR USE WITH IMPLANTABLE NEUROSTIMULATOR, REPLACEMENT ONLY	NON-COVERED	CMP200602	PRIOR AUTHORIZATION REQUIRED - FOLLOW MEDICARE COVERAGE CRITERIA	CMS	
L8701	POWERED UPPER EXTREMITY RANGE OF MOTION ASSIST DEVICE, ELBOW, WRIST, HAND WITH SINGLE OR DOUBLE UPRIGHT(S), INCLUDES MICROPROCESSOR, SENSORS, ALL COMPONENTS AND ACCESSORIES, CUSTOM FABRICATED	NON-COVERED	CMP202406	NON-COVERED	CMP202406	
L8702	POWERED UPPER EXTREMITY RANGE OF MOTION ASSIST DEVICE, ELBOW, WRIST, HAND, FINGER, SINGLE OR DOUBLE UPRIGHT(S), INCLUDES MICROPROCESSOR, SENSORS, ALL COMPONENTS AND ACCESSORIES, CUSTOM FABRICATED	NON-COVERED	CMP202406	NON-COVERED	CMP202406	
M0076	PROLOTHERAPY	NON-COVERED	CMP201105	PRIOR AUTHORIZATION NOT REQUIRED		
Q4103	OASIS BURN MATRIX, PER SQUARE CENTIMETER	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4108	INTEGRA MATRIX, PER SQUARE CENTIMETER	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4110	PRIMATRIX, PER SQUARE CENTIMETER	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4111	GAMMAGRAFT, PER SQUARE CENTIMETER	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4115	ALLOSKIN, PER SQUARE CENTIMETER	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4117	HYALOMATRIX, PER SQUARE CENTIMETER	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4118	MATRISTEM MICROMATRIX, 1 MG	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4123	ALLOSKIN RT, PER SQUARE CENTIMETER	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4126	MEMODERM, DERMASPAN, TRANZGRAFT OR INTEGUPLY, PER SQUARE CENTIMETER	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4127	TALYMED, PER SQUARE CENTIMETER	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4134	HMATRIX, PER SQUARE CENTIMETER	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4135	MEDISKIN, PER SQUARE CENTIMETER	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4136	EZ-DERM, PER SQUARE CENTIMETER	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4137	AMNIOEXCEL, AMNIOEXCEL PLUS OR BIODEXCEL, PER SQUARE CENTIMETER	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4140	BIODFENCE, PER SQUARE CENTIMETER	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4141	Alloskin ac, per square centimeter	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4146	TENSIX, PER SQUARE CENTIMETER	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4147	ARCHITECT, ARCHITECT PX, OR ARCHITECT FX, EXTRACELLULAR MATRIX, PER SQUARE CENTIMETER	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4148	NEOX CORD 1K, NEOX CORD RT, OR CLARIX CORD 1K, PER SQUARE CENTIMETER	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4152	DERMAPURE, PER SQUARE CENTIMETER	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4153	DERMAVEST AND PLURIVEST, PER SQUARE CENTIMETER	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4154	BIOVANCE, PER SQUARE CENTIMETER	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4156	NEOX 100 OR CLARIX 100, PER SQUARE CENTIMETER	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4157	REVITALON, PER SQUARE CENTIMETER	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4158	KERECIS OMEGA3, PER SQUARE CENTIMETER	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4159	AFFINITY, PER SQUARE CENTIMETER	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4160	NUSHIELD, PER SQUARE CENTIMETER	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4161	BIO-CONNEKT WOUND MATRIX, PER SQUARE CENTIMETER	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4162	WOUNDEX FLOW, BIOSKIN FLOW, 0.5 CC	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4163	WOUNDEX, BIOSKIN, PER SQUARE CENTIMETER	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4164	HELICOLL, PER SQUARE CENTIMETER	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4165	Keramatrix or kerasorb, per square centimeter	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4166	CYTAL, PER SQUARE CENTIMETER	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4167	TRUSKIN, PER SQUARE CENTIMETER	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4169	ARTACENT WOUND, PER SQUARE CENTIMETER	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4170	CYGNUS, PER SQUARE CENTIMETER	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4173	PALINGEN OR PALINGEN XPLUS, PER SQUARE CENTIMETER	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4175	MIRODERM, PER SQUARE CENTIMETER	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4176	NEOPATCH OR THERION, PER SQUARE CENTIMETER	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4178	FLOWERAMNIOPATCH, PER SQUARE CENTIMETER	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		

Codes	Code Description	Medical Mutual Commercial	Medical Mutual Commercial Criteria	Medicare Advantage	Medicare Advantage Criteria	Details/Notes
Q4180	REVITA, PER SQUARE CENTIMETER	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4181	AMNIO WOUND, PER SQUARE CENTIMETER	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4185	CELLESTA FLOWABLE AMNION (25 MG PER CC); PER 0.5 CC	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4187	EPICORD, PER SQUARE CENTIMETER	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4188	AMNIOARMOR, PER SQUARE CENTIMETER	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4195	PURAPLY, PER SQUARE CENTIMETER	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4196	PURAPLY AM, PER SQUARE CENTIMETER	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4197	PURAPLY XT, PER SQUARE CENTIMETER	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4198	Genesis amniotic membrane, per square centimeter	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4200	Skin te, per square centimeter	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4201	MATRION, PER SQUARE CENTIMETER	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4202	Keroxx (2.5g/cc), 1cc	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4203	DERMA-GIDE, PER SQUARE CENTIMETER	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4204	Xwrap, per square centimeter	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4224	HUMAN HEALTH FACTOR 10 AMNIOTIC PATCH (HHF10-P), PER SQUARE CENTIMETER	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4225	AMNIOBIND, PER SQUARE CENTIMETER	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4256	MYOWN SKIN, INCLUDES HARVESTING AND PREPARATION PROCEDURES, PER SQUARE CENTIMETER	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4257	RELESE, PER SQUARE CENTIMETER	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4258	ENVERSE, PER SQUARE CENTIMETER	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4259	CELERA DUAL LAYER OR CELERA DUAL MEMBRANE, PER SQUARE CENTIMETER	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4260	SIGNATURE APATCH, PER SQUARE CENTIMETER	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4261	TAG, PER SQUARE CENTIMETER	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4262	DUAL LAYER IMPAX MEMBRANE, PER SQUARE CENTIMETER	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4263	SURGRAFT TL, PER SQUARE CENTIMETER	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4264	COCOON MEMBRANE, PER SQUARE CENTIMETER	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4265	Neostim tl, per square centimeter	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4266	Neostim membrane, per square centimeter	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4267	Neostim dl, per square centimeter	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4268	Surgraft ft, per square centimeter	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4269	Surgraft xt, per square centimeter	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4270	Complete sl, per square centimeter	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4271	Complete ft, per square centimeter	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4272	ESANO A, PER SQUARE CENTIMETER	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4273	ESANO AAA, PER SQUARE CENTIMETER	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4274	ESANO AC, PER SQUARE CENTIMETER	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4275	ESANO ACA, PER SQUARE CENTIMETER	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4276	ORION, PER SQUARE CENTIMETER	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4278	EPIEFFECT, PER SQUARE CENTIMETER	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4279	"Vendaje ac, per square centimeter"	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4280	☒CELL AMNIO MATRIX, PER SQUARE CENTIMETER	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4281	BARRERA SL OR BARRERA DL, PER SQUARE CENTIMETER	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4282	©YGNUS DUAL, PER SQUARE CENTIMETER	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4283	BIOVANCE TRI-LAYER OR BIOVANCE 3L, PER SQUARE CENTIMETER	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4284	Dermabind sl, per square centimeter	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4285	NUDYN DL OR NUDYN DL MESH, PER SQUARE CENTIMETER	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4286	NUDYN SL OR NUDYN SLW, PER SQUARE CENTIMETER	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4287	"Dermabind dl, per square centimeter"	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4288	DERMABIND CH, PER SQ CM	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4289	REVOSHIELD+ AMNIOTIC BARRIER, PER SQ CM	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4290	MEMBRANE WRAP-HYDRO(TM), PER SQ CM	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4291	LAMELLAS XT, PER SQ CM	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4292	LAMELLAS, PER SQ CM	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4293	ACESSO DL, PER SQ CM	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4294	AMNIO QUAD-CORE, PER SQ CM	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4295	AMNIO TRI-CORE AMNIOTIC, PER SQ CM	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4296	REBOUND MATRIX, PER SQ CM	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4297	EMERGE MATRIX, PER SQ CM	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4298	AMNICORE PRO, PER SQ CM	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4299	AMNICORE PRO+, PER SQ CM	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4300	ACESSO TL, PER SQ CM	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		

Codes	Code Description	Medical Mutual Commercial	Medical Mutual Commercial Criteria	Medicare Advantage	Medicare Advantage Criteria	Details/Notes
Q4301	ACTIVATE MATRIX, PER SQ CM	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4302	COMPLETE ACA, PER SQ CM	NON-COVERED	CMP200233	PRIOR AUTHORIZATION REQUIRED - MEDICAL POLICY	CMS	
Q4303	COMPLETE AA, PER SQ CM	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4304	GRAFIX PLUS, PER SQ CM	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4305	AMERICAN AMNION AC TRI-LAYER, PER SQ CM	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4306	AMERICAN AMNION AC, PER SQ CM	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4307	AMERICAN AMNION, PER SQ CM	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4308	SANOPELLIS, PER SQ CM	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4309	VIA MATRIX, PER SQ CM	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4310	PROCENTA, PER 100 MG	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4311	Acesso, per square centimeter	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4312	Acesso ac, per square centimeter	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4313	Dermabind fm, per square centimeter	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4314	Reeva ft, per square centimeter	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4315	Regenelink amniotic membrane allograft, per square centimeter	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4316	Amchoplast, per square centimeter	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4317	Vitograft, per square centimeter	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4318	E-graft, per square centimeter	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4319	Sanograft, per square centimeter	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4320	Pellograft, per square centimeter	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4321	Renograft, per square centimeter	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4322	Caregraft, per square centimeter	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4323	Alloply, per square centimeter	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4324	Amniotx, per square centimeter	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4325	Acapatch, per square centimeter	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4326	Woundplus, per square centimeter	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4327	Duoamnion, per square centimeter	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4328	Most, per square centimeter	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4329	Singlay, per square centimeter	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4330	Total, per square centimeter	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4331	Axolotl graft, per square centimeter	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4332	Axolotl dualgraft, per square centimeter	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4333	Ardeograft, per square centimeter	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4334	Amnioplast 1, per square centimeter	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4335	Amnioplast 2, per square centimeter	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4336	Artacent c, per square centimeter	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4337	Artacent trident, per square centimeter	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4338	Artacent velos, per square centimeter	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4339	Artacent vericlen, per square centimeter	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4340	Simpligraft, per square centimeter	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4341	Simplimax, per square centimeter	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4342	Theramend, per square centimeter	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4343	Dermacyte ac matrix amniotic membrane allograft, per square centimeter	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4344	Tri-membrane wrap, per square centimeter	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4345	Matrix hd allograft dermis, per square centimeter	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4346	Shelter dm matrix, per square centimeter	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4347	Rampart dl matrix, per square centimeter	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4348	Sentry sl matrix, per square centimeter	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4349	Mantle dl matrix, per square centimeter	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4350	Palisade dm matrix, per square centimeter	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4351	Enclose tl matrix, per square centimeter	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4352	Overlay sl matrix, per square centimeter	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4353	Xceed tl matrix, per square centimeter	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4383	AXOLOTL GRAFT ULTRA, PER SQ CM	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4384	AXOLOTL DUALGRAFT ULTRA, PER SQ CM	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4385	APOLLO FT PER SQ CM	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4386	ACESSO TRIFACA, PER SQ CM	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4387	NEOTHELIUM FT, PER SQ CM	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4388	NEOTHELIUM 4L, PER SQ CM	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4389	NEOTHELIUM 4L PLUS, PER SQ CM	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4390	ASCENDION, PER SQ CM	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		

Codes	Code Description	Medical Mutual Commercial	Medical Mutual Commercial Criteria	Medicare Advantage	Medicare Advantage Criteria	Details/Notes
Q4391	AMNIOPLAST DOUBLE, PER SQ CM	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4392	GRAFIX DUO, PER SQ CM	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4393	SURGRAFT AC, PER SQ CM	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4394	SURGRAFT ACA, PER SQ CM	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4395	ACELAGRAFT, PER SQ CM	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4396	NATALIN, PER SQ CM	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
Q4397	SUMMIT AAA, PER SQ CM	NON-COVERED	CMP200233	PRIOR AUTHORIZATION NOT REQUIRED		
S0515	SCLERAL LENS, LIQUID BANDAGE DEVICE, PER LENS	NON-COVERED	CMP2006-G	NON-COVERED		
S2348	Decompression procedure, percutaneous, of nucleus pulposus of intervertebral disc, using radiofrequency energy, single or multiple levels, lumbar	NON-COVERED	CMP2019-G	NON-COVERED		
S8040	Topographic brain mapping	NON-COVERED	MCG A-1050 (CMP202406)	NON-COVERED		
S8130	INTERFERENTIAL CURRENT STIMULATOR, 2 CHANNEL	NON-COVERED	CMP201004	NON-COVERED		
S8131	INTERFERENTIAL CURRENT STIMULATOR, 4 CHANNEL	NON-COVERED	CMP201004	NON-COVERED		
0948T	INTERROGATION DEVICE EVALUATION (REMOTE), UP TO 90 DAYS, CARDIAC CONTRACTILITY MODULATION SYSTEM WITH INTERIM ANALYSIS, REVIEW, AND REPORT(S) BY A PHYSICIAN OR OTHER QUALIFIED HEALTH CARE PROFESSIONAL	NON-COVERED	CMP202406	NON-COVERED		
0949T	INTERROGATION DEVICE EVALUATION (REMOTE), UP TO 90 DAYS, CARDIAC CONTRACTILITY MODULATION SYSTEM, REMOTE DATA ACQUISITION(S), RECEIPT OF TRANSMISSIONS, TECHNICIAN REVIEW, TECHNICAL SUPPORT, AND DISTRIBUTION OF RESULTS	NON-COVERED	CMP202406	NON-COVERED		
0950T	ABLATION OF BENIGN PROSTATE TISSUE, TRANSRECTAL, WITH HIGH INTENSITY-FOCUSED ULTRASOUND (HIFU), INCLUDING ULTRASOUND GUIDANCE	NON-COVERED	CMP202406	NON-COVERED		
0951T	TOTALLY IMPLANTABLE ACTIVE MIDDLE EAR HEARING IMPLANT; INITIAL PLACEMENT, INCLUDING MASTOIDECTOMY, PLACEMENT OF AND ATTACHMENT TO SOUND PROCESSOR	NON-COVERED	CMP202406	NON-COVERED		
0952T	TOTALLY IMPLANTABLE ACTIVE MIDDLE EAR HEARING IMPLANT; REVISION OR REPLACEMENT, WITH MASTOIDECTOMY AND REPLACEMENT OF SOUND PROCESSOR	NON-COVERED	CMP202406	NON-COVERED		
0953T	TOTALLY IMPLANTABLE ACTIVE MIDDLE EAR HEARING IMPLANT; REVISION OR REPLACEMENT, WITHOUT MASTOIDECTOMY AND REPLACEMENT OF SOUND PROCESSOR	NON-COVERED	CMP202406	NON-COVERED		
0954T	TOTALLY IMPLANTABLE ACTIVE MIDDLE EAR HEARING IMPLANT; REPLACEMENT OF SOUND PROCESSOR ONLY, WITH ATTACHMENT TO EXISTING TRANSDUCERS	NON-COVERED	CMP202406	NON-COVERED		
0955T	TOTALLY IMPLANTABLE ACTIVE MIDDLE EAR HEARING IMPLANT; REMOVAL, INCLUDING REMOVAL OF SOUND PROCESSOR AND ALL IMPLANT COMPONENTS	NON-COVERED	CMP202406	NON-COVERED		
0956T	PARTIAL CRANIECTOMY, CHANNEL CREATION, AND TUNNELING OF ELECTRODE FOR SUB-SCALP IMPLANTATION OF AN ELECTRODE ARRAY, RECEIVER, AND TELEMETRY UNIT FOR CONTINUOUS BILATERAL ELECTROENCEPHALOGRAPHY MONITORING SYSTEM, INCLUDING IMAGING GUIDANCE	NON-COVERED	CMP202406	NON-COVERED		
0957T	REVISION OF SUB-SCALP IMPLANTED ELECTRODE ARRAY, RECEIVER, AND TELEMETRY UNIT FOR ELECTRODE, WHEN REQUIRED, INCLUDING IMAGING GUIDANCE	NON-COVERED	CMP202406	NON-COVERED		
0958T	REMOVAL OF SUB-SCALP IMPLANTED ELECTRODE ARRAY, RECEIVER, AND TELEMETRY UNIT FOR CONTINUOUS BILATERAL ELECTROENCEPHALOGRAPHY MONITORING SYSTEM, INCLUDING IMAGING GUIDANCE	NON-COVERED	CMP202406	NON-COVERED		
0959T	REMOVAL OR REPLACEMENT OF MAGNET FROM COIL ASSEMBLY THAT IS CONNECTED TO CONTINUOUS BILATERAL ELECTROENCEPHALOGRAPHY MONITORING SYSTEM, INCLUDING IMAGING GUIDANCE	NON-COVERED	CMP202406	NON-COVERED		
0960T	REPLACEMENT OF SUB-SCALP IMPLANTED ELECTRODE ARRAY, RECEIVER, AND TELEMETRY UNIT WITH TUNNELING OF ELECTRODE FOR CONTINUOUS BILATERAL ELECTROENCEPHALOGRAPHY MONITORING SYSTEM, INCLUDING IMAGING GUIDANCE	NON-COVERED	CMP202406	NON-COVERED		
0961T	SHORTWAVE INFRARED RADIATION IMAGING, SURGICAL PATHOLOGY SPECIMEN, TO ASSIST GROSS EXAMINATION FOR LYMPH NODE LOCALIZATION IN FIBROADIPOSE TISSUE, PER SPECIMEN (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)	NON-COVERED	CMP202406	NON-COVERED		

Codes	Code Description	Medical Mutual Commercial	Medical Mutual Commercial Criteria	Medicare Advantage	Medicare Advantage Criteria	Details/Notes
0962T	ASSISTIVE ALGORITHMIC ANALYSIS OF ACOUSTIC AND ELECTROCARDIOGRAM RECORDING FOR DETECTION OF CARDIAC DYSFUNCTION (EG, REDUCED EJECTION FRACTION, CARDIAC MURMURS, ATRIAL FIBRILLATION), WITH REVIEW AND INTERPRETATION BY A PHYSICIAN OR OTHER QUALIFIED HEALTH CARE PROFESSIONAL	NON-COVERED	CMP202406	NON-COVERED		
0963T	ANOSCOPY WITH DIRECTED SUBMUCOSAL INJECTION OF BULKING AGENT INTO ANAL CANAL	NON-COVERED	CMP202406	NON-COVERED		
0964T	IMPRESSION AND CUSTOM PREPARATION OF JAW EXPANSION ORAL PROSTHESIS FOR OBSTRUCTIVE SLEEP APNEA, INCLUDING INITIAL ADJUSTMENT; SINGLE ARCH, WITHOUT MANDIBULAR ADVANCEMENT MECHANISM	NON-COVERED	CMP202406	NON-COVERED		
0965T	IMPRESSION AND CUSTOM PREPARATION OF JAW EXPANSION ORAL PROSTHESIS FOR OBSTRUCTIVE SLEEP APNEA, INCLUDING INITIAL ADJUSTMENT; DUAL ARCH, WITH ADDITIONAL MANDIBULAR ADVANCEMENT, NON-FIXED HINGE MECHANISM	NON-COVERED	CMP202406	NON-COVERED		
0966T	IMPRESSION AND CUSTOM PREPARATION OF JAW EXPANSION ORAL PROSTHESIS FOR OBSTRUCTIVE SLEEP APNEA, INCLUDING INITIAL ADJUSTMENT; DUAL ARCH, WITH ADDITIONAL MANDIBULAR ADVANCEMENT, FIXED HINGE MECHANISM	NON-COVERED	CMP202406	NON-COVERED		
0967T	TRANSANAL INSERTION OF ENDOLUMINAL TEMPORARY COLORECTAL ANASTOMOSIS PROTECTION DEVICE, INCLUDING VACUUM ANCHORING COMPONENT AND FLEXIBLE SHEATH CONNECTED TO EXTERNAL VACUUM SOURCE AND MONITORING SYSTEM	NON-COVERED	CMP202406	NON-COVERED		
0968T	INSERTION OR REPLACEMENT OF EPICRANIAL NEUROSTIMULATOR SYSTEM, INCLUDING ELECTRODE ARRAY AND PULSE GENERATOR, WITH CONNECTION TO ELECTRODE ARRAY	NON-COVERED	CMP202406	NON-COVERED		
0969T	REMOVAL OF EPICRANIAL NEUROSTIMULATOR SYSTEM	NON-COVERED	CMP202406	NON-COVERED		
0970T	ABLATION, BENIGN BREAST TUMOR (EG, FIBROADENOMA), PERCUTANEOUS, LASER, INCLUDING IMAGING GUIDANCE WHEN PERFORMED, EACH TUMOR	NON-COVERED	CMP202406	NON-COVERED		
0971T	ABLATION, MALIGNANT BREAST TUMOR(S), PERCUTANEOUS, LASER, INCLUDING IMAGING GUIDANCE WHEN PERFORMED, UNILATERAL	NON-COVERED	CMP202406	NON-COVERED		
0972T	ASSISTIVE ALGORITHMIC CLASSIFICATION OF BURN HEALING (IE, HEALING OR NONHEALING) BY NONINVASIVE MULTISPECTRAL IMAGING, INCLUDING SYSTEM SET-UP AND ACQUISITION, SELECTION, AND TRANSMISSION OF IMAGES, WITH AUTOMATED GENERATION OF REPORT	NON-COVERED	CMP202406	NON-COVERED		
0973T	SELECTIVE ENZYMATIC DEBRIDEMENT, PARTIAL-THICKNESS AND/OR FULL-THICKNESS BURN ESCHAR, REQUIRING ANESTHESIA (IE, GENERAL ANESTHESIA, MODERATE SEDATION), INCLUDING PATIENT MONITORING, TRUNK, ARMS, LEGS; FIRST 100 SQ CM	NON-COVERED	CMP202406	NON-COVERED		
0974T	SELECTIVE ENZYMATIC DEBRIDEMENT, PARTIAL-THICKNESS AND/OR FULL-THICKNESS BURN ESCHAR, REQUIRING ANESTHESIA (IE, GENERAL ANESTHESIA, MODERATE SEDATION), INCLUDING PATIENT MONITORING, TRUNK, ARMS, LEGS; EACH ADDITIONAL 100 SQ CM (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)	NON-COVERED	CMP202406	NON-COVERED		
0975T	SELECTIVE ENZYMATIC DEBRIDEMENT, PARTIAL-THICKNESS AND/OR FULL-THICKNESS BURN ESCHAR, REQUIRING ANESTHESIA (IE, GENERAL ANESTHESIA, MODERATE SEDATION), INCLUDING PATIENT MONITORING, SCALP, NECK, HANDS, FEET, AND/OR MULTIPLE DIGITS; FIRST 100 SQ CM	NON-COVERED	CMP202406	NON-COVERED		
0976T	SELECTIVE ENZYMATIC DEBRIDEMENT, PARTIAL-THICKNESS AND/OR FULL-THICKNESS BURN ESCHAR, REQUIRING ANESTHESIA (IE, GENERAL ANESTHESIA, MODERATE SEDATION), INCLUDING PATIENT MONITORING, SCALP, NECK, HANDS, FEET, AND/OR MULTIPLE DIGITS; EACH ADDITIONAL 100 SQ CM (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)	NON-COVERED	CMP202406	NON-COVERED		
0977T	UPPER GASTROINTESTINAL BLOOD DETECTION, SENSOR CAPSULE, WITH INTERPRETATION AND REPORT	NON-COVERED	CMP202406	NON-COVERED		
0978T	SUBMUCOSAL CRYOLYSIS THERAPY; SOFT PALATE, BASE OF TONGUE, AND LINGUAL TONSIL	NON-COVERED	CMP202406	NON-COVERED		
0979T	SUBMUCOSAL CRYOLYSIS THERAPY; SOFT PALATE, BASE OF TONGUE, AND LINGUAL TONSIL	NON-COVERED	CMP202406	NON-COVERED		
0980T	SUBMUCOSAL CRYOLYSIS THERAPY; BASE OF TONGUE AND LINGUAL TONSIL ONLY	NON-COVERED	CMP202406	NON-COVERED		

Codes	Code Description	Medical Mutual Commercial	Medical Mutual Commercial Criteria	Medicare Advantage	Medicare Advantage Criteria	Details/Notes
0981T	TRANSCATHETER IMPLANTATION OF WIRELESS INFERIOR VENA CAVA SENSOR FOR LONG-TERM HEMODYNAMIC MONITORING, INCLUDING DEPLOYMENT OF THE SENSOR, RADIOLOGICAL SUPERVISION AND INTERPRETATION, RIGHT HEART CATHETERIZATION, AND INFERIOR VENA CAVA VENOGRAPHY, WHEN PERFORMED	NON-COVERED	CMP202406	NON-COVERED		
0982T	REMOTE MONITORING OF IMPLANTABLE INFERIOR VENA CAVA SENSOR, PHYSIOLOGIC PARAMETER(S) (EG, WEIGHT, BLOOD PRESSURE, PULSE OXIMETRY, RESPIRATORY FLOW RATE), INITIAL SET-UP AND PATIENT EDUCATION ON USE OF EQUIPMENT	NON-COVERED	CMP202406	NON-COVERED		
0983T	REMOTE MONITORING OF AN IMPLANTED INFERIOR VENA CAVA SENSOR FOR UP TO 30 DAYS, INCLUDING AT LEAST WEEKLY DOWNLOADS OF INFERIOR VENA CAVA AREA RECORDINGS, INTERPRETATION(S), TREND ANALYSIS, AND REPORT(S) BY A PHYSICIAN OR OTHER QUALIFIED HEALTH CARE PROFESSIONAL	NON-COVERED	CMP202406	NON-COVERED		
0984T	INTRAVASCULAR IMAGING OF EXTRACRANIAL CEREBRAL VESSELS USING OPTICAL COHERENCE TOMOGRAPHY (OCT) DURING DIAGNOSTIC EVALUATION AND/OR THERAPEUTIC INTERVENTION, INCLUDING ALL ASSOCIATED RADIOLOGICAL SUPERVISION, INTERPRETATION, AND REPORT; INITIAL VESSEL (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)	NON-COVERED	CMP202406	NON-COVERED		
0985T	INTRAVASCULAR IMAGING OF EXTRACRANIAL CEREBRAL VESSELS USING OPTICAL COHERENCE TOMOGRAPHY (OCT) DURING DIAGNOSTIC EVALUATION AND/OR THERAPEUTIC INTERVENTION, INCLUDING ALL ASSOCIATED RADIOLOGICAL SUPERVISION, INTERPRETATION, AND REPORT; EACH ADDITIONAL VESSEL (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)	NON-COVERED	CMP202406	NON-COVERED		
0986T	INTRAVASCULAR IMAGING OF INTRACRANIAL CEREBRAL VESSELS USING OPTICAL COHERENCE TOMOGRAPHY (OCT) DURING DIAGNOSTIC EVALUATION AND/OR THERAPEUTIC INTERVENTION, INCLUDING ALL ASSOCIATED RADIOLOGICAL SUPERVISION, INTERPRETATION, AND REPORT; INITIAL VESSEL (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)	NON-COVERED	CMP202406	NON-COVERED		
0987T	INTRAVASCULAR IMAGING OF INTRACRANIAL CEREBRAL VESSELS USING OPTICAL COHERENCE TOMOGRAPHY (OCT) DURING DIAGNOSTIC EVALUATION AND/OR THERAPEUTIC INTERVENTION, INCLUDING ALL ASSOCIATED RADIOLOGICAL SUPERVISION, INTERPRETATION, AND REPORT; EACH ADDITIONAL VESSEL (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)	NON-COVERED	CMP202406	NON-COVERED		

Spreadsheet Change History (initiated 4/17/2025)

7/1/2025 - Added procedure code 15770
7/1/2025 - Updated criteria CPT 15830
7/1/2025 - Updated criteria CPT 58563
7/1/2025 - Updated criteria CPT 15756
7/1/2025 - Updated criteria for Cochlear implant - Primary codes (69714, 69716, 69717, 69719) added Criteria for Hybrid Cochlear Implants
7/1/2025 - Updated criteria for CPT 69930
7/1/2025 - Updated criteria for CPT 19303
7/1/2025 - CPT 37241, 37242, 37243 Removed, refer to Investigational policies for specific services
7/1/2025 - Updated criteria for CPT 21230, 21235, 20912
7/1/2025 - Updated criteria CPT 19318
7/1/2025 - Updated criteria CPT 22551, 22552, 22554
7/1/2025 - Removed CPT 75894 and 75898, refer to investigationalpolicies for specific services.
7/1/2025 - Removed CPT 61888
7/1/2025 - Updated CPT 31571 notes section
7/1/2025 - Removed CPT 57106, 56625, 56800, 57295
7/1/2025 - Updated notes for CPT 19328
7/1/2025 - Removed CPT 61886
7/1/2025 - Updated criteria for CPT 49906
7/1/2025 - Updated criteria for CPT 58552
7/1/2025 - Updated criteria for HCPC Q4170
7/1/2025 - Added 0205U for both Commercial and Medicare as prior auth required
7/1/2025 - Removed J0600 for both Commercial and Medicare
7/1/2025 - Remove M0300 for both Commercial and Medicare
7/1/2025 - Removed 53860 for both Commercial and Medicare

Codes	Code Description	Medical Mutual Commercial	Medical Mutual Commercial Criteria	Medicare Advantage	Medicare Advantage Criteria	Details/Notes
7/1/2025 - Updated criteria for Leadless pacemaker and associated components and services.						
8/1/2025 - 0780T code removed for Medicare and Commercial						
8/1/2025 - Add CPT 56625 56800 57106 57295 to require prior auth for gender affirming diagnosis codes for Commercial & Medicare effective 8/1/25. Subject to members eligibility for these services.						
8/1/2025 - Corrected criteria for 27278 to CMS for Medicare						
8/1/2025 - Added investigational/experimental and not standard of care list for Commercial and Medicare						
8/1/2025 - Updated 0587T and 0588T to CMP202406 for Commercial and Medicare **(move to phase II IE revision list)**						
9/1/2025 - Added investigational/experimental and not standard of care list for Commercial and Medicare						
9/1/2025 - Update criteria for 36468 for Commercial to CMP201929						
9/1/2025 - Update criteria for 31830 for Commercial to CMP201929						
9/1/2025 - Moved 30117 to investigational/experimental list						
9/1/2025 - Remove prior auth requirement for 37700 for Commercial only						
9/1/2025 - Added prior auth required for Commercial only when for EMDR therapy 90832 90833 90834 90836 90837 90838 90839 90840 90845 90846 90847 90849 90853 90863 90865 90867 90868 90869 90870 90875 90876 90880 90882 90885 90887 90889 90899						
10/1/2025 - Remove 95970, 95976, 95977 for both Commercial and Medicare						
10/1/2025 - Remove E0737 for both Commercial and Medicare						
10/1/2025 - Remove prior auth requirement for Medicare only for Q4186, Q4187						
10/1/2025 - Updated criteria for procedure code 21235 to CMP201929						
10/1/2025 - L8681 removed CMP201914 for Commercial only						
10/1/2025 - Updated criteria for 63650, 63655, 63661, 63662, 63663, 63664, 63685, 63688 to MCG for Commercial only						
10/1/2025 - L8680 updated criteria to CMP202406 and CMP201004 for Commercial only						
10/1/2025 - Remove 37700 for both Commercial and Medicare						
10/1/2025 - Add Q4368, Q4369, Q4370, Q4371, Q4372, Q4373, Q4375, Q4376, Q4377, Q4378, Q4379, Q4380, Q4381, and 19105 to IE/non-covered section for Commercial						
10/1/2025 - Add 0052U, 0553U, 0554U, 0555U, 0560U, 0561U, 0562U, 0565U, 0566U, 0567U, 0569U, 0571U, 0572U to IE/non-covered section for Commercial only						
11/1/2025 - Update criteria for Commercial for 58262 to CMP201609, MCG						
11/1/2025 - Move CPT code 64568 to PA required for both Commercial and Medicare						
11/1/2025 - Remove PA requirement for 59070 59076 59897 59899 S2400 S2401 S2402 S2403 S2404 S2405 S2409 for both lines of business						
11/1/2025 - Add 0575U 0576U 0577U 0578U 0582U 0583U 0585U 0586U 0591U 0592U 0597U to IE/not standard of care for Commercial						
11/1/2025 -Remove Q4101 for both Commercial and Medicare						
11/1/2025 - Add 0600T and 0601T to IE/not standard of care for both Commercial and Medicare						
12/1/2025-Add 0326U for both Commercial and Medicare						
12/1/2025 Update Commercial criteria for codes 0446T, 0447T, 0448T to CMP200117						
12/1/2025-Update Commercial and Medicare criteria for 0402T to MCG						
12/1/2025-Update Commercial and Medicare critera for L8701 and L8702 to CMP202406						
12/1/2025 Add E0658 and E0659 for both Commercial and Medicare to IE/not standard of care						
12/1/2025-Add A2036, A2037, A2038, A2039, Q4383, Q4384, Q4385,Q4386, Q4387, Q4388,Q4389, Q4390, Q4391, Q4392, Q4393, Q4394, Q4395, Q4396, Q4397 to IE/not standard of care for Commercial						
12/1/2025-Add 926065 and 92066 for both Commercial and Medicare						
12/1/2025-Remove 96110, 96116, 97110, 97112, 97116, 97530, 97533, 97535, 97537 for both Commercial and Medicare						