



Coverage of any medical or drug intervention discussed in this document is subject to the limitations and exclusions outlined in the member's benefit certificate or summary plan description (SPD) and to applicable state and/or federal laws.

## Medica Central Master Service List (MSL)



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### **General Information**

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The codes listed on this document may not be an all-inclusive list of codes that require prior authorization and/or have coverage limitations. If you are unable to find the information you need, please contact the Medica Central Customer Care Center at the appropriate number below:

- Individual and Marketplace Plans: (877) 379-7599 (TTY 711)
- SSM Health Employee Health Plan: (877) 274-4693 (TTY: 711)
- Medica Employee Health Plan: (833) 942-2159 (TTY: 711)

The [complete library of medical policies](#) is available on [Medica Central Health Plan.com](#).



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## Submission Information

### Medica Central Health Plan Commercial Insurance

- Providers are responsible for submitting prior authorizations for Medica Central Health Plan Commercial members with **HMO** or **POS (In-Network Provider)** plans; and
- Medica Central Health Plan Commercial members with **PPO** or **POS (Out-of-Network Provider)** plans need to verify that their provider has submitted a prior authorization before the service is performed in order to avoid incurring additional financial liability.
- Network providers please submit prior authorizations through the [Availity Essentials Portal](#).
- Prior Authorization Forms may be accessed by clicking [here](#).

### Medica Central Health Plan Administrative Services Only (ASO) SSM Health Employee Health Plan

- The [SSM Health Employee Medical Plan page](#) contains information on benefit documents, medical management and out of area coverage.
- ASO members – contracted ASO providers are responsible for submitting prior authorizations for ASO members.
- For all other providers, Medica Central Health Plan ASO members need to verify that their providers have submitted a prior authorization before the service is performed in order to avoid incurring additional financial liability.
- For ASO plan members, prior authorization and plan coverage of any medical intervention discussed in the Medica Central Health Plan Master Service List (MSL) is subject to the requirements outlined in the member's Summary Plan Description (SPD). You can access the member's SPD through the [Provider Portal](#) or by calling the member's plan Customer Service number found in the [General Information section](#).
- Authorizations for members in our ASO (Administrative Services Only) plan types (payer ID 75261) should be submitted via email to [ifbhealthmanagement@medica.com](mailto:ifbhealthmanagement@medica.com) or via fax to 1 (608) 252-0830 on the relevant form found on our Utilization Management page under Prior Authorization Forms: [Medical Management page for SSM Health Employees](#);

### Medica Employee Health Plan

- The [Medica Employee Benefit Plan page](#) contains information on benefit documents, medical management and out of area coverage. .
- EHP EPO members – contracted ASO and Prevea360 network providers are responsible for submitting prior authorizations for Medica Employee Health Plan members.
- Prior authorizations must be submitted via email or
  - Authorizations for members in our ASO (Administrative Services Only) plan types (payer ID 75261) should be submitted via email to [ifbhealthmanagement@medica.com](mailto:ifbhealthmanagement@medica.com) or via fax to 1 (608) 252-0830 on the relevant form found on our Utilization Management page under Prior Authorization Forms: [Medical Management page for Medica Employees](#);



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**Medicare Advantage Insurance**

- Review the **Medicare Coverage Guidelines**, established by the Centers for Medicare & Medicaid Services (CMS) to determine which services require prior authorization. According to the guidelines, all medical care, services, supplies, and equipment must be medically necessary.
- In scenarios where CMS does not provide guidance on the particular medical care, service, supplies, or equipment, we will use MCG (formerly Milliman Care Guidelines) criteria or our medical policy. See our **Medical Services Prior Authorization List** (PDF) to review medical policies relevant to the services you are requesting.
- Prior authorization can be submitted by the provider, member, or member's representative.
- Network providers please submit prior authorizations through the [Availity Essentials Portal](#).



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### **Prior Authorization Information**

- *The codes listed on this document may **not** be an all-inclusive list of codes that require prior authorization and/or have coverage limitations.*
- *Use the current applicable CPT/HCPCS code(s). The following codes included in this document are for informational purposes only and are subject to change without notice. Inclusion or exclusion of a code does not constitute or imply member coverage or provider reimbursement.*

#### **Codes that require prior authorization:**

- Providers are responsible for submitting prior authorizations for Medica Central Health Plan members with IFB, EHP EPO or POS (In-Network Provider) plans.
- For all other providers, Medica Central Health Plan EHP PPO members need to verify that their providers have submitted a prior authorization before the service is performed in order to avoid incurring additional financial liability.

#### **Codes that do not require prior authorization:**

- A prior authorization is NOT required when provided by an in-network provider under the member's plan.
- A Prior Authorization will NOT be processed for these requests and will be cancelled as not required if submitted.
- An appropriate diagnosis code must appear on the claim; claims will deny in the absence of an appropriate diagnosis code.
- If a claim is submitted without a diagnosis code considered Medically Necessary, the claim will deny unless coverage is mandated by state/federal laws.
- If these services are provided by an out-of-network provider for an EPO or HMO, use of an out-of-network provider must be authorized prior to the service.
- Denied claims will be addressed through the provider appeal process.
- Prior authorization is not required. However, services with specific coverage criteria may be reviewed retrospectively to determine if criteria are being met. Retrospective denial may result if criteria are not met

#### **Codes that are not covered:**

- A Prior Authorization will NOT be processed for these requests and will be cancelled as not covered if submitted.
- Prior authorization, if submitted, will be cancelled as not covered for the service.
- If a claim is submitted the claim will deny unless coverage is mandated by state/federal laws.
- Denied claims will be addressed through the provider appeal process.
- Claims for this service are subject to retrospective review and denial of coverage, as investigative services are not eligible for reimbursement



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### Providers without Access to the Medica Central Health Plan Provider Portal

If the provider does not have access to Availity Essentials Portal, request is for an ASO member, or for a medical injectable, please follow steps below:

- The various Authorization Request forms can be found on the [Medical Management page of Medica Central.com](#);
- Authorization request forms should be mailed, emailed or faxed on the date the request has been completed to ensure timely processing of the authorization request;
- Please complete all fields on the top part of the form in their entirety, otherwise the Medica Central Health Plan Utilization Management Department will return it to the referring physician for completion.
- When an authorization is requested to a non-contracted provider, please include as much information as possible regarding why the request is being submitted and the plan provider(s) that the member has already seen. The Medica Central Health Plan Utilization Management Department will review the authorization request to ensure that (1) medically necessary care has been requested and that (2) the service(s) requested are not available with plan providers.

All written Authorization Request forms must be either faxed, emailed or mailed to Medica Central Health Plan using the following information:

<b>Fax Number</b>	<b>(608) 252-0830</b>
<b>Email</b>	<a href="mailto:ifbhealthmanagement@medica.com">ifbhealthmanagement@medica.com</a>
<b>Mailing Address</b>	Medica Central Health Plan ATTN: Utilization Management P.O. Box 56099 Madison, WI 53705

**NOTE:** Any prior authorization submitted as 'Medically Urgent' that does not meet the definition of medically urgent may be changed to non-urgent/standard. This determination is made only by medically licensed personnel, and includes a call to the requesting provider's office advising of this change and determination.

**NOTE:** Only services that are not provided within the Medica Central Health Plan provider network are considered for approval with a non-contracted provider.

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## **Carelon Prior Authorization**

Medica Central Health Plan is partnering with Carelon, a utilization management (UM) program third-party vendor, to support the provider submission and medical necessity review process for all related authorizations. These select MSK, cardiology and high-tech radiology procedures and services will include but are not limited to: hip, knee and shoulder arthroscopy; various interventional pain management injections such as sacroiliac joint injections; imaging such as MRI, MRA and CT scans; angioplasty and stent placement; implantable pacemakers; and vascular imaging.

Prior authorization requests for musculoskeletal (MSK), cardiology or radiology services managed through Carelon, please [submit to Carelon here](#). See Carelon's [cardiology policies](#), [radiology policies](#) and [MSK policies](#)

The Carelon provider portal is available 7 days a week, fully interactive, and processes requests in real time using clinical criteria. Or call Carelon toll-free at 1 (833) 476-1463, Monday through Friday, 8 a.m.-5 p.m. CT.

Excluded services include:

- Procedures performed in an inpatient setting (i.e., those services performed during an inpatient stay) or on an emergent basis (i.e., those services performed as part of being evaluated at the ER and prior to the patient's discharge from the hospital) are not included in the Carelon cardiology and radiology programs.
- Procedures performed on an emergent basis (as part of being evaluated at the ER and prior to the patient's discharge from the hospital) are not included in the Carelon MSK program.
- Applicable to the following Medica Central Health Plan product lines:
  - Commercial – Medica Health HMO, Medica Health POS and Medica Health PPO
  - Administrative Services Only (ASO) includes SSM Health Employee Health Plan and Medica Employee Health Plan



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Medica Central Policy Name with Link	Prevea360 Policy Name with Link for Medica Employee Health Plan members who use the Prevea360 network.	Prior Authorization Status	Prior Authorization Required for these Current Procedural Terminology (CPT) Codes	Prior Authorization Not Required for the Covered Current Procedural Terminology (CPT) Codes	Not Covered Current Procedural Terminology (CPT) Codes <small>*The codes listed below are not a comprehensive list of non-covered codes. General or miscellaneous non-covered codes are not listed.</small>
<a href="#">Actigraphy MP9559</a>	<a href="#">Actigraphy MP9559</a>	Not Required	NA	95803	NA
<a href="#">Air Ambulance, Non-Emergent MP9632</a>	<a href="#">Air Ambulance, Non-Emergent MP9632</a>	Non-emergent air ambulance transport requires prior authorization	A0140, A0430, A0431, A0435, A0436, S9960, S9961	NA	NA
<a href="#">Allogenic Morphogenic Protein (OsteoAMP) MP9776</a>	<a href="#">Allogenic Morphogenic Protein (OsteoAMP) MP9776</a>	Not covered	NA	NA	If a claim is submitted, the claim will deny unless coverage is mandated by state/federal laws.
<a href="#">Amino Acid-Based Elemental Formulas MP9355</a>	<a href="#">Amino Acid-Based Elemental Formulas MP9355</a>	Not Required	NA	B4153, B4161	NA
<a href="#">Annulus Fibrosis Repair Devices MP9688</a>	<a href="#">Annulus Fibrosis Repair Devices MP9688</a>	Not Covered	NA	NA	C9757
<a href="#">Autologous Blood-Derived Products (Platelet-Rich Plasma, Autologous Conditioned Serum, Autologous Whole Blood MP9713</a>	<a href="#">Autologous Blood-Derived Products (Platelet-Rich Plasma, Autologous Conditioned Serum, Autologous Whole Blood MP9713</a>	Not Covered	NA	NA	0232T, 0481T, G0465, P9020, S9055





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<a href="#">Automated, Non-Invasive Nerve Conduction Velocity (NCV) Testing MP9689</a>	<a href="#">Automated, Non-Invasive Nerve Conduction Velocity (NCV) Testing MP9689</a>	Not covered	NA	NA	95905
<a href="#">Bariatric Surgery MP9319</a>	<a href="#">Bariatric Surgery MP9319</a>	Required	43770, 43771, 43772, 43773, 43775, 43842, 43843, 43848, 43860, 43865, 43886, 43887, 43888 <ul style="list-style-type: none"> <li>• 43644, 43645 only requires a prior authorization if related to bariatric surgery or when performed for weight management</li> <li>• 43659 and 43999 require prior authorization when related to bariatric surgery</li> </ul>	NA	43290, 43291, 0312T
<a href="#">Biochemical Biomarker Panel for Assessment of Hepatitis-Associated Liver Disease MP9674</a>	<a href="#">Biochemical Biomarker Panel for Assessment of Hepatitis-Associated Liver Disease MP9674</a>	Not required	NA	Use applicable CPT or HCPCS codes	0002M, 0003M, 81517, 0166U
<a href="#">Bioimpedance Spectroscopy (BIS)</a>	<a href="#">Bioimpedance Spectroscopy (BIS)</a>	Not covered	NA	NA	93702, 0358T

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<a href="#">and Bioelectrical Impedance Analysis (BIA) MP9690</a>	<a href="#">and Bioelectrical Impedance Analysis (BIA) MP9690</a>				
<a href="#">Birth Centers (Free-Standing) MP9666</a>	<a href="#">Birth Centers (Free-Standing) MP9666</a>	Not required	NA	Use applicable CPT or HCPCS codes	NA
<a href="#">Blood Coagulation Home Testing Devices MP9788</a>	<a href="#">Blood Coagulation Home Testing Devices MP9788</a>	Not required	NA	G0248, G0249, G0250	NA
<a href="#">Bone Anchored Hearing Aid MP9018</a>	<a href="#">Bone Anchored Hearing Aid MP9018</a>	Not required	NA	69710, 69711 , 69714, 69715, 69716, 69717, 69719, 69728, 69729, 69730, L8690, L8691, L8692, L8693, L8694, S2230, V5095	NA
<a href="#">Bone Growth Stimulators -Electrical (Long Bones) And Ultrasound MP9076 (III-DEV.07)</a>	<a href="#">Bone Growth Stimulators -Electrical (Long Bones) And Ultrasound MP9076 (III-DEV.07)</a>	Required	20974, 20975, 20979, E0747, E0748, E0749, E0760	NA	NA
<a href="#">Bone Marrow or Stem Cell (Peripheral or Umbilical Cord) Transplantation MP9611</a>	<a href="#">Bone Marrow or Stem Cell (Peripheral or Umbilical Cord) Transplantation MP9611</a>	Required	Prior authorization is required for evaluation and actual transplant. 38204, 38205, 38206, 38207, 38208, 38209, 38210, 38211, 38212, 38213, 38214, 38215,	NA	NA

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			38230, 38232, 38240, 38241, 38242, 38243, S2150		
<a href="#">Breast Ductal Lavage MP9691</a>	<a href="#">Breast Ductal Lavage MP9691</a>	Not covered	NA	NA	19499
<a href="#">Breast Implant Removal, Revision, or Reimplantation MP9580</a>	<a href="#">Breast Implant Removal, Revision, or Reimplantation MP9580</a>	Required	19328, 19330, 19340, 19342, 19370, 19371, 19380	Breast implant removal, revision, or reimplantation associated with breast reconstruction following a mastectomy AND the procedure will be coded as such does not require prior authorization.	NA
<a href="#">Bronchial Thermoplasty for Treatment of Asthma MP9693</a>	<a href="#">Bronchial Thermoplasty for Treatment of Asthma MP9693</a>	Not covered	NA	NA	If a claim is submitted, the claim will deny unless coverage is mandated by state/federal laws.
<a href="#">Cala Trio Therapy for Essential Tremor MP9757</a>	<a href="#">Cala Trio Therapy for Essential Tremor MP9757</a>	Not covered	NA	NA	E0734



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<a href="#">Cardiac Event Monitors and Procedures MP9540</a>	<a href="#">Cardiac Event Monitors and Procedures MP9540</a>	Not required	NA	Use applicable CPT or HCPCS codes	NA
<p><u>Cardiology -</u></p> <p><i>See Carelon website - <a href="https://guidelines.carelonmedicalbenefitsmanagement.com/current-cardiology-guidelines/">https://guidelines.carelonmedicalbenefitsmanagement.com/current-cardiology-guidelines/</a></i></p> <p>Click <a href="#">here</a> for additional information on Carelon prior authorization.</p> <p><b>Note:</b> Effective 10/01/2024, prior authorization for the services listed in the chart to the right will be submitted to Carelon.</p> <p>Procedures performed in an inpatient setting (i.e., those services performed during an inpatient stay) or on an emergent basis</p>	<p><u>Cardiology -</u></p> <p><i>See Carelon website - <a href="https://guidelines.carelonmedicalbenefitsmanagement.com/current-cardiology-guidelines/">https://guidelines.carelonmedicalbenefitsmanagement.com/current-cardiology-guidelines/</a></i></p> <p>Click <a href="#">here</a> for additional information on Carelon prior authorization.</p> <p><b>Note:</b> Effective 10/01/2024, prior authorization for the services listed in the chart to the right will be submitted to Carelon.</p> <p>Procedures performed in an inpatient setting (i.e., those services performed during an inpatient stay) or on an emergent basis</p>	<p>Required through Carelon for these services:</p> <ul style="list-style-type: none"> <li>• Cardiac Resynchronization Therapy</li> <li>• Diagnostic Coronary Angiography</li> <li>• Endovascular Revascularization</li> <li>• Imaging of the Heart</li> <li>• Implantable Cardioverter Defibrillators</li> <li>• Percutaneous Implantable Pacemakers</li> <li>• Vascular Imaging</li> </ul>	<p>0505T, 0571T, 0572T, 0573T, 0574T, 0620T, 0795T, 0796T, 0797T, 0798T, 0799T, 0800T, 0801T, 0802T, 0803T, 0804T, 33206, 33207, 33208, 33212, 33213, 33214, 33215, 33216, 33217, 33218, 33220, 33221, 33222, 33223, 33224, 33226, 33227, 33228, 33229, 33230, 33231, 33233, 33240, 33241, 33244, 33249, 33262, 33263, 33264, 33270, 33271, 33272, 33273, 33274, 33275, 37220, 37221, 37224, 37225, 37226, 37227, 37228, 37229, 37230, 37231, 92920, 92924, 92928, 92933, 92937, 92943, 93303, 93304, 93306, 93307, 93308, 93312, 93313, 93314, 93315, 93316, 93317, 93350, 93351, 93454, 93455, 93456, 93457, 93458, 93459, 93460, 93461, 93880, 93882, 93922, 93923, 93924, 93925, 93926, 93930, 93931, 93978, 93979, C1721, C1722, C1777, C1785, C1786, C1882, C1895, C1896, C1899, C2619, C2620, C2621, C7531, C7534, C7535, C7537, C7538, C7539, C7540, C9600, C9601, C9602, C9603, C9604, C9605, C9607, C9608, G0448</p>	NA	NA



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(i.e., those services performed as part of being evaluated at the ER and prior to the patient's discharge from the hospital) are not included in the Caredon cardiology program.	(i.e., those services performed as part of being evaluated at the ER and prior to the patient's discharge from the hospital) are not included in the Caredon cardiology program.				
<a href="#">Carotid Intima-Media Thickness Measurement MP9694</a>	<a href="#">Carotid Intima-Media Thickness Measurement MP9694</a>	Not covered	NA	NA	93895
<a href="#">Cell Therapy for the Treatment of Cardiac Disease MP9578</a>	<a href="#">Cell Therapy for the Treatment of Cardiac Disease MP9578</a>	Not required	NA	Use applicable CPT or HCPCS codes	0263T, 0264T, 0265T
<a href="#">Chemiluminescent Testing (ViziLite) for Oral Cancer Screening MP9569</a>	<a href="#">Chemiluminescent Testing (ViziLite) for Oral Cancer Screening MP9569</a>	Not required	NA	Use applicable CPT or HCPCS codes	NA
<a href="#">Chemoembolization for Hepatic Tumors MP9462</a>	<a href="#">Chemoembolization for Hepatic Tumors MP9462</a>	Not required	NA	Use applicable CPT or HCPCS codes	NA
<a href="#">Chronic Rhinitis: Cryoablation, Radiofrequency Ablation and Laser</a>	<a href="#">Chronic Rhinitis: Cryoablation, Radiofrequency Ablation and Laser</a>	Not required	NA	Use applicable CPT or HCPCS codes	NA



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<a href="#">Ablation, Office-Based MP9631</a>	<a href="#">Ablation, Office-Based MP9631</a>				
<a href="#">CLEAR Institute Scoliosis Treatment Protocols MP9695</a>	<a href="#">CLEAR Institute Scoliosis Treatment Protocols MP9695</a>	Not covered	NA	NA	E1399
<a href="#">Clinical Trials (Clinical Trial Participation) MP9447</a>	<a href="#">Clinical Trials (Clinical Trial Participation) MP9447</a>	Not required **Specialized lab evaluations and medical images which are part of standard of care but cannot be performed at a plan site <b>require</b> prior authorization through the Health Services Division.	NA	Use applicable CPT or HCPCS codes	NA
<a href="#">Cognitive Rehabilitation/Remediation MP9561</a>	<a href="#">Cognitive Rehabilitation/Remediation MP9561</a>	Not required	NA	Use applicable CPT or HCPCS codes	NA
<a href="#">Collagen Cross Links as Markers of Bone Turnover MP9677</a>	<a href="#">Collagen Cross Links as Markers of Bone Turnover MP9677</a>	Not covered	NA	NA	82523
<a href="#">Computerized Dynamic Posturography MP9696</a>	<a href="#">Computerized Dynamic Posturography MP9696</a>	Not covered	NA	NA	92548, 92549

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<a href="#">Confocal Laser Endomicroscopy for Barrett's Esophagus MP9697</a>	<a href="#">Confocal Laser Endomicroscopy for Barrett's Esophagus MP9697</a>	Not covered	NA	NA	43206, 43252, 0397T if billed with the following diagnosis codes: K227.10, K227.11, K227.19.
<a href="#">Continuous Glucose Monitoring (CGM) Systems, Implantable (e.g., Eversense) MP9791</a>	<a href="#">Continuous Glucose Monitoring (CGM) Systems, Implantable (e.g., Eversense) MP9791</a>	Not required	NA	0446T, 0447T, 0448T	NA
<a href="#">Corneal Cross-Linking (CXL) MP9470</a>	<a href="#">Corneal Cross-Linking (CXL) MP9470</a>	Not required	NA	Use applicable CPT or HCPCS codes	NA
<a href="#">Cosmetic and Reconstructive Surgery Abdominoplasty/ Panniculectomy MP9646</a>  <a href="#">Blepharoplasty, Blepharoptosis Repair, and Brow Lift MP9664</a>  <a href="#">Rhinoplasty Procedure with or without Septoplasty MP9648</a>	<a href="#">Cosmetic and Reconstructive Surgery Abdominoplasty/ Panniculectomy MP9646</a>  <a href="#">Blepharoplasty, Blepharoptosis Repair, and Brow Lift MP9664</a>  <a href="#">Rhinoplasty Procedure with or without Septoplasty MP9648</a>	Required	15820, 15821, 15822, 15823, 15830, 15839, 15847, 15877, 30400, 30410, 30420, 30430, 30435, 30450, 30460, 30462, 30465, 30468, 67900, 67901, 67902, 67903, 67904, 67906, 67908, 67909, 69300 If specific policy does not apply, requests will be reviewed as per member plan documents, Cosmetic and/or Reconstructive Surgery	NA	NA





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<a href="#">Otoplasty MP9647 (III-SUR.33)</a>	<a href="#">Otoplasty MP9647 (III-SUR.33)</a>				
<a href="#">Cranial Electrotherapy Stimulation (CES) MP9698</a>	<a href="#">Cranial Electrotherapy Stimulation (CES) MP9698</a>	Not covered	NA	NA	E0732, A4596
<a href="#">Craniosacral Therapy MP9699</a>	<a href="#">Craniosacral Therapy MP9699</a>	Not covered	NA	NA	97139
<a href="#">Cytotoxic Testing for Allergy Diagnosis MP9678</a>	<a href="#">Cytotoxic Testing for Allergy Diagnosis MP9678</a>	Not covered	NA	NA	86807, 86808
<a href="#">Day Treatment – Behavioral Health MP9557</a>	<a href="#">Day Treatment – Behavioral Health MP9557</a>	Not required	NA	Use applicable CPT or HCPCS codes	NA
<a href="#">Diagnosis and Treatment of Chronic Cerebrospinal Venous Insufficiency (CCSVI) in Multiple Sclerosis MP9568</a>	<a href="#">Diagnosis and Treatment of Chronic Cerebrospinal Venous Insufficiency (CCSVI) in Multiple Sclerosis MP9568</a>	Not covered	NA	NA	If a claim is submitted, the claim will deny unless coverage is mandated by state/federal laws.
<a href="#">Drug Eluting Sinus Stents, Bioabsorbable MP9700</a>	<a href="#">Drug Eluting Sinus Stents, Bioabsorbable MP9700</a>	Not covered	NA	NA	S1091
<a href="#">Durable Medical Equipment MP9347</a>	<a href="#">Durable Medical Equipment MP9347</a>	Not required or Not covered	NA	A4670, 99473, 99474	T2039, E0240, E0247, E0248, E0625, E0190, E0218, E0935, E0936,

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				*Please review policy to determine the criteria required for claims coverage of this service.	E0118, S9433, S9434, A4660, E0244, A9281, A4520, T4521, T4522, T4523, T4524, T4529, T4530, T4538, T4525, T4526, T4527, T4528, T4529, T4531, T4532, T4533, T4534, T4535, T4536, T4537, T4539, T4540, T4541, T4543, T4544, E0210, E0215, E1300, K1003, E0189, E0700, A8001, A8002, A8003, A8004, S0516, E0203, A4634, S9090, E0625, E0605, E0710, E1310 92618, E2506, E2508, E2510, E2511, E2512, E2599, *E1399, *K0108,  *If the item is identified by a 'miscellaneous' or 'unspecified' codes and there is a more specific medical policy applicable to the item you must reference the more specific medical policy for criteria.



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<a href="#">Elastography (Ultrasound, Acoustic Radiation Force Impulse Imaging and Shear Wave Elastography) MP9562</a>	<a href="#">Elastography (Ultrasound, Acoustic Radiation Force Impulse Imaging and Shear Wave Elastography) MP9562</a>	Not required	NA	76391, 76981, 76982, 76983, 91200	NA
<a href="#">Electric Cell-Signaling Treatment (e.g., neoGEN® System, Sanexas Intl.) MP9701</a>	<a href="#">Electric Cell-Signaling Treatment (e.g., neoGEN® System, Sanexas Intl.) MP9701</a>	Not covered	NA	NA	64999, 13999
<a href="#">Electric Tumor Treatment Field (Optune) MP9474</a>	<a href="#">Electric Tumor Treatment Field (Optune) MP9474</a>	Not covered	NA	E0766	A4555
<a href="#">Electrical or Electromagnetic Stimulation for Healing of Chronic Wounds MP9702</a>	<a href="#">Electrical or Electromagnetic Stimulation for Healing of Chronic Wounds MP9702</a>	Not required	NA	E0769, G0281, G0282 when meets policy criteria.	NA
<a href="#">Electromagnetic Navigation Bronchoscopy MP9634</a>	<a href="#">Electromagnetic Navigation Bronchoscopy MP9634</a>	Not required	NA	Use applicable CPT or HCPCS codes	NA
<a href="#">Endoscopic Balloon Sinuplasty Ostial Dilation Chronic Sinusitis MP9667</a>	<a href="#">Endoscopic Balloon Sinuplasty Ostial Dilation Chronic Sinusitis MP9667</a>	Not required	NA	Use applicable CPT or HCPCS codes	NA

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<a href="#">Endoscopic Procedures for the Treatment of Gastroesophageal Reflux Disease (GERD) MP9703</a>	<a href="#">Endoscopic Procedures for the Treatment of Gastroesophageal Reflux Disease (GERD) MP9703</a>	Not covered	NA	NA	43257
<a href="#">Endoscopic Radiofrequency Ablation for Barrett's Esophagus MP9628</a>	<a href="#">Endoscopic Radiofrequency Ablation for Barrett's Esophagus MP9628</a>	Not required	NA	Use applicable CPT or HCPCS codes	43257
<a href="#">Enhanced External Counterpulsation (EECP) MP9620</a>	<a href="#">Enhanced External Counterpulsation (EECP) MP9620</a>	Not required	NA	Use applicable CPT or HCPCS codes	NA
<a href="#">Epidural Lysis of Adhesions MP9704</a>	<a href="#">Epidural Lysis of Adhesions MP9704</a>	Not covered	NA	NA	62263, 62264
<a href="#">Eustachian Tube Balloon Dysfunction (Acclarent AERA) MP9604</a>	<a href="#">Eustachian Tube Balloon Dysfunction (Acclarent AERA) MP9604</a>	Not required	NA	69705, 69706, 69799	NA
<a href="#">Exhaled Breath Tests for Asthma and Other Inflammatory Pulmonary Conditions: Exhaled Nitric Oxide Breath Test and Exhaled Breath</a>	<a href="#">Exhaled Breath Tests for Asthma and Other Inflammatory Pulmonary Conditions: Exhaled Nitric Oxide Breath Test and Exhaled Breath</a>	Not required	NA	83987, 95012	NA

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<a href="#">Condensate pH Measurement MP9560</a>	<a href="#">Condensate pH Measurement MP9560</a>				
<a href="#">Extended Hours of Home Care (Private Duty Nursing) MP9766 (III-HOM.01)</a>	<a href="#">Extended Hours of Home Care (Private Duty Nursing) MP9766</a>	Required	Use applicable CPT or HCPCS codes	NA	NA
<a href="#">Extracorporeal Magnetic Stimulation for the Treatment of Urinary Incontinence MP9705</a>	<a href="#">Extracorporeal Magnetic Stimulation for the Treatment of Urinary Incontinence MP9705</a>	Not covered	NA	NA	53899
<a href="#">Extracorporeal Photophoresis (Photochemotherapy) MP9558</a>	<a href="#">Extracorporeal Photophoresis (Photochemotherapy) MP9558</a>	Not Required	NA	36522	NA
<a href="#">Extracorporeal Shock Wave Therapy (ESWT) for Musculoskeletal Indications and Soft Tissue Injuries MP9706</a>	<a href="#">Extracorporeal Shock Wave Therapy (ESWT) for Musculoskeletal Indications and Soft Tissue Injuries MP9706</a>	Not covered	NA	NA	28890, 0101T, 0102T, 0512T, 0513T
<a href="#">Eye-Movement Analysis without Spatial Calibration</a>	<a href="#">Eye-Movement Analysis without Spatial Calibration</a>	Not covered	NA	NA	0615T



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<a href="#">(e.g., EyeBOX® system) MP9785</a>	<a href="#">(e.g., EyeBOX® system) MP9785</a>				
<a href="#">Facility-Based Polysomnography (Sleep Studies) for Obstructive Sleep Apnea, Adults MP9676 (III-DIA.16)</a>	<a href="#">Facility-Based Polysomnography (Sleep Studies) for Obstructive Sleep Apnea, Adults MP9676 (III-DIA.16)</a>	Required	95807, 95808, 95810. 95811 - Please note: these codes are applicable for 18 years and older.	NA	NA
<a href="#">Fecal Calprotectin Testing MP9665</a>	<a href="#">Fecal Calprotectin Testing MP9665</a>	Not required	NA	Use applicable CPT or HCPCS codes	NA
<a href="#">Female Breast Reduction Surgery – Reduction Mammoplasty MP9582 (III-SUR.27)</a>	<a href="#">Female Breast Reduction Surgery – Reduction Mammoplasty MP9582 (III-SUR.27)</a>	Required	19318	NA	NA
<a href="#">Female External Urinary Catheters for Urinary Incontinence (e.g., PureWick, PrimaFit) MP9759</a>	<a href="#">Female External Urinary Catheters for Urinary Incontinence (e.g., PureWick, PrimaFit) MP9759</a>	Not covered	NA	NA	A6590, E2001
<a href="#">Food Allergy/Intolerance Testing (in vitro) MP9679</a>	<a href="#">Food Allergy/Intolerance Testing (in vitro) MP9679</a>	Not required	NA	Use applicable CPT or HCPCS codes	86001



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<a href="#">Foot Care MP9656</a>	<a href="#">Foot Care MP9656</a>	Not required	NA	Use applicable CPT or HCPCS codes	NA
<a href="#">Functional Electrical Stimulation, Upper and Lower Limb MP9566</a>	<a href="#">Functional Electrical Stimulation, Upper and Lower Limb MP9566</a>	Not required	NA	Use applicable CPT or HCPCS codes	E0770, E0764
<a href="#">Gastric Electrical Stimulation (GES) MP9463</a>	<a href="#">Gastric Electrical Stimulation (GES) MP9463</a>	Not required	NA	Use applicable CPT or HCPCS codes	NA
<a href="#">Gastrointestinal Monitoring System (SmartPill®) MP9707</a>	<a href="#">Gastrointestinal Monitoring System (SmartPill®) MP9707</a>	Not covered	NA	NA	91112
<a href="#">Gender Affirmation Procedures MP9642</a>	<a href="#">Gender Affirmation Procedures MP9642</a>	Required	<p><b>Prior authorization required if billed with any of the following diagnosis codes:</b> F64.0 F64.1 F64.2 F64.8 F64.9 Z87.890;</p> <p><b>Procedures:</b></p> <p>15839, 15877, 19301, 19302, 19303, 19304, 19305, 19306, 19307, 19316, 19318, 19325, 19350, 53415, 53420, 53425, 53430, 54120, 54125, 54130, 54135, 54400, 54401, 54405, 54520, 54522, 54660, 54690, 55175, 55180, 55866, 55970, 55980, 56625, 56800, 56805, 57106, 57107, 57109, 57110, 57111, 57112, 57291, 57292, 57335, 58150, 58152, 58180, 58200, 58210, 58260, 58262,</p>	NA	NA



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			58263, 58267, 58270, 58275, 58280, 58285, 58290, 58291, 58292, 58293, 58294, 58541, 58542, 58543, 58550, 58552, 58553, 58554, 58570, 58571, 58572, 58573, 58661, 58720, 11920, 11921, 11922, 11950, 11951, 11952, 11954, 14000, 14001, 14041, 15734, 15738, 15750, 15757, 15758, 15769, 15771, 15772, 15773, 15774, 15780, 15781, 15783, 15786, 15787, 15788, 15789, 15792, 15793, 15819, 15824, 15825, 15826, 15828, 15829, 15832, 15833, 15834, 15835, 15836, 15837, 15838, 15876, 15878, 15879, 17380, 17999, 21137, 21138, 21139, 21172, 21175, 21179, 21180, 21208, 21209, 21210, 21215, 21230, 21235, 21270, 21899, 31599, 31899, 40799, 53410, 56620, 56810, 58544, 58940, 64856, 64892, 64896		
<a href="#">Genetic Testing: General Approach to Genetic Testing MP9610</a>	<a href="#">Genetic Testing: General Approach to Genetic Testing MP9610</a>	Not required	NA	Use applicable CPT or HCPCS codes	NA
<a href="#">Glaucoma Surgical Treatments MP9467</a>	<a href="#">Glaucoma Surgical Treatments MP9467</a>	Not required	NA	Use applicable CPT or HCPCS codes	NA



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<a href="#">Hair Analysis in the Clinical Setting MP9680</a>	<a href="#">Hair Analysis in the Clinical Setting MP9680</a>	Not covered	NA	NA	P2031
<a href="#">Hearing Aids MP9445</a>	<a href="#">Hearing Aids MP9445</a>	Not required	NA	V5030, V5040, V5050, V5060, V5070, V5080, V5095, V5100, V5120, V5130, V5140, V5150, V5171, V5172, V5181, V5190, V5211, V5212, V5213, V5214, V5215, V5221, V5230, V5242, V5243, V5244, V5245, V5246, V5247, V5248, V5249, V5250, V5251, V5252, V5253, V5254, V5255, V5256, V5257, V5258, V5259, V5260, V5261, V5262, V5263, V5298	V5266
<a href="#">Heart\Lung Transplantation MP9612</a>	<a href="#">Heart\Lung Transplantation MP9612</a>	Required	Prior authorization is required for evaluation and actual transplant. 33930, 33933, 33935.	NA	NA
<a href="#">Heart Transplantation (Adult and Pediatric) MP9613</a>	<a href="#">Heart Transplantation (Adult and Pediatric) MP9613</a>	Required	Prior authorization is required for evaluation and actual transplant. 33940, 33944, 33945.	NA	NA
<a href="#">High Frequency Chest Wall Compression</a>	High Frequency Chest Wall Compression	Required	E0483, A7025, A7026	NA	NA





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<a href="#">(HFCWC) Devices MP9235</a>	(HFCWC) Devices MP9235				
<a href="#">High Intensity Focused Ultrasound (HIFU) and Magnetic Resonance Guided Focused Ultrasound (MRgFUS) MP9708</a>	<a href="#">High Intensity Focused Ultrasound (HIFU) and Magnetic Resonance Guided Focused Ultrasound (MRgFUS) MP9708</a>	Not covered	NA	NA	0071T, 0072T, 0398T, 55880, C9734
<a href="#">Home Traction, Cervical and Lumbar MP9781</a>	<a href="#">Home Traction, Cervical and Lumbar MP9781</a>	Not covered	NA	NA	If a claim is submitted, the claim will deny unless coverage is mandated by state/federal laws.
<a href="#">Home Use of Bilevel Positive Airway Pressure (BiPAP) for Conditions Other Than Obstructive Sleep Apnea (OSA) MP9658</a>	<a href="#">Home Use of Bilevel Positive Airway Pressure (BiPAP) for Conditions Other Than Obstructive Sleep Apnea (OSA) MP9658</a>	Not required	NA	21120, 21121, 21122, 21123, 21199, 42145, E0470, E0471, E0472, E0485, E0486, E0601, A9279	0437T, 64582, 64584
<a href="#">Home Use of Continuous Positive Airway Pressure (CPAP) and Bilevel Positive Airway Pressure (BiPAP) for Sleep Apnea MP9239</a>	<a href="#">Home Use of Continuous Positive Airway Pressure (CPAP) and Bilevel Positive Airway Pressure (BiPAP) for Sleep Apnea MP9239</a>	Not required	NA	21120, 21121, 21122, 21123, 21199, 42145, E0470, E0471, E0472, E0485, E0486, E0601, A9279	0437T, 64582, 64584



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<a href="#">Hospice (Inpatient and Outpatient) Services MP9299</a>	<a href="#">Hospice (Inpatient and Outpatient) Services MP9299</a>	Not required	NA	Q5001, Q5002 Q5003 Q5004 Q5005 Q5006 Q5007 Q5008 Q5010 G0182 G9473 G9474 G9475 G9476 G9477 G9478 G9479 G0337 S0255	NA
<a href="#">Hyperbaric Oxygen Therapy and Topical Oxygen MP9055</a>	<a href="#">Hyperbaric Oxygen Therapy and Topical Oxygen MP9055</a>	Not required	*Self-funded plans (ASO) may require prior authorization. Please refer to the member's Summary Plan Description (SPD) or call the Customer Service number found on the member's card for specific prior authorization requirements.	Use applicable CPT or HCPCS codes	A4575, E0446
<a href="#">I-Factor Bone Graft MP9777</a>	<a href="#">I-Factor Bone Graft MP9777</a>	Not covered	NA	NA	If a claim is submitted, the claim will deny unless coverage is mandated by state/federal laws.
<a href="#">Implantable Deep Brain and Responsive Cortical Stimulation MP9331</a>	<a href="#">Implantable Deep Brain and Responsive Cortical Stimulation MP9331</a>	Not required	NA	61885, 61886	NA



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<a href="#">Implantable Peripheral Nerve Stimulator for Treatment of Pain MP9769</a>	<a href="#">Implantable Peripheral Nerve Stimulator for Treatment of Pain MP9769</a>	Not covered	NA	NA	If a claim is submitted, the claim will deny unless coverage is mandated by state/federal laws.
<a href="#">Implanted Hypoglossal Nerve Stimulation for Treatment of Obstructive Sleep Apnea MP9636</a>	<a href="#">Implanted Hypoglossal Nerve Stimulation for Treatment of Obstructive Sleep Apnea MP9636</a>	Required	64568, 64582, 64583	NA	41521
<a href="#">Inhaled Nitric Oxide Therapy MP9654</a>	<a href="#">Inhaled Nitric Oxide Therapy MP9654</a>	Not required	NA	Use applicable CPT or HCPCS codes	NA
<a href="#">Inpatient (Hospital) Level of Care MP9671 (III-INP.01)</a>	<a href="#">Inpatient (Hospital) Level of Care MP9671 (III-INP.01)</a>	Required	Prior authorization is required for elective inpatient admission and continued stay; Notification of all inpatient admissions is required as specified in the hospital participation agreement, provider contracts and/or provider manuals.	NA	NA
<a href="#">Inpatient Rehabilitation (Acute Rehabilitation) MP9668 (III-INP.05)</a>	<a href="#">Inpatient Rehabilitation (Acute Rehabilitation) MP9668 (III-INP.05)</a>	Required	Prior authorization required for admission and continued stay.	NA	NA



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<a href="#">Intense Pulsed Light Treatment for Dry Eye Disease MP9709</a>	<a href="#">Intense Pulsed Light Treatment for Dry Eye Disease MP9709</a>	Not covered	NA	NA	0507T
<a href="#">Intensive Outpatient - Behavioral Health MP9556</a>	<a href="#">Intensive Outpatient - Behavioral Health MP9556</a>	Not required	NA	Use applicable CPT or HCPCS codes	NA
<a href="#">Interferential Current Stimulation MP9710</a>	<a href="#">Interferential Current Stimulation MP9710</a>	Not covered	NA	NA	S8130, S8131, E1399
<a href="#">Intestinal Transplantation MP9618 (III-TRA.13)</a>	<a href="#">Intestinal Transplantation MP9618 (III-TRA.13)</a>	Required	Prior authorization is required for evaluation and actual transplant. 44132, 44133, 47133, 44135, 44136, 44137, 44715, 44720, 44721, 47135, 47140, 47141, 47142, 47143, 47144, 47145, 47146, 47147.	NA	NA
<a href="#">Intradiscal Electrothermal (IDET) MP9711</a>	<a href="#">Intradiscal Electrothermal (IDET) MP9711</a>	Not covered	NA	NA	22526, 22527
<a href="#">Intraoperative Neurophysiological Monitoring (IONM) MP9577</a>	<a href="#">Intraoperative Neurophysiological Monitoring (IONM) MP9577</a>	Not required	NA	Use applicable CPT or HCPCS codes	NA
<a href="#">Intravascular Shockwave Lithotripsy</a>	<a href="#">Intravascular Shockwave Lithotripsy</a>	Not covered	NA	NA	C1761, 92972

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<a href="#">for the Treatment of Coronary Artery Disease MP9770</a>	<a href="#">for the Treatment of Coronary Artery Disease MP9770</a>				
<a href="#">In Vitro Chemosensitivity and Chemoresistance Assays MP9760</a>	<a href="#">In Vitro Chemosensitivity and Chemoresistance Assays MP9760</a>	Not covered	NA	NA	0564T, 0083U
<a href="#">Iris Prosthesis MP9715</a>	<a href="#">Iris Prosthesis MP9715</a>	Not covered	NA	NA	0616T, 0617T, 0618T, C1839
<a href="#">Irreversible Electroporation (NanoKnife System) MP9714</a>	<a href="#">Irreversible Electroporation (NanoKnife System) MP9714</a>	Not covered	NA	NA	0600T, 0601T
<a href="#">Kidney Transplantation MP9675 (III-TRA.03)</a>	<a href="#">Kidney Transplantation MP9675 (III-TRA.03)</a>	Required	Prior authorization is required for evaluation and actual transplant. 50300, 50320, 50323, 50325, 50327, 50328, 50329, 50340, 50360, 50365, 50370, 50380, 50547.	NA	NA
<a href="#">Laboratory Testing MP9539</a>	<a href="#">Laboratory Testing MP9539</a>	Not required	NA	Use applicable CPT or HCPCS codes	NA
<a href="#">Laser Spine Surgeries MP9768</a>	<a href="#">Laser Spine Surgeries MP9768</a>	Not covered	NA	NA	62287



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<a href="#">Laser Therapy for Nicotine Dependence MP9717</a>	<a href="#">Laser Therapy for Nicotine Dependence MP9717</a>	Not covered	NA	NA	S8948
<a href="#">Laser Therapy for Treatment of Pain MP9718</a>	<a href="#">Laser Therapy for Treatment of Pain MP9718</a>	Not covered	NA	NA	0552T, S8948
<a href="#">Light Treatment and Laser Therapies for Benign Dermatologic Conditions MP9057</a>	<a href="#">Light Treatment and Laser Therapies for Benign Dermatologic Conditions MP9057</a>	Not required	NA	Use applicable CPT or HCPCS codes	NA
<a href="#">Lipoprotein-associated Phospholipase A2 (Lp-PLA2) Immunoassay for Prediction of Risk of Coronary Heart Disease or Ischemic Stroke (PLAC Test®) MP9687</a>	<a href="#">Lipoprotein-associated Phospholipase A2 (Lp-PLA2) Immunoassay for Prediction of Risk of Coronary Heart Disease or Ischemic Stroke (PLAC Test®) MP9687</a>	Not covered	NA	NA	83698
<a href="#">Lipoprotein Subclass Testing for Screening, Evaluation and Monitoring of Cardiovascular Disease MP9681</a>	<a href="#">Lipoprotein Subclass Testing for Screening, Evaluation and Monitoring of Cardiovascular Disease MP9681</a>	Not covered	NA	NA	83700, 83701, 83704, 83772, 0052U, 0377U



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<a href="#">Liposuction for the Treatment of Lymphedema or Lipedema MP9650</a>	<a href="#">Liposuction for the Treatment of Lymphedema or Lipedema MP9650</a>	Not required	NA	15877, 15878, 15879	NA
<a href="#">Liver Transplantation MP9614 (III-TRA.02)</a>	<a href="#">Liver Transplantation MP9614 (III-TRA.02)</a>	Required	Prior authorization is required for evaluation and actual transplant. 00796, 47133, 47135, 47140, 47141, 47142, 47143, 47144, 47145, 47146, 47147.	NA	NA
<a href="#">Long Term Acute Care Hospital (LTACH) MP9669 (III-INP.04)</a>	<a href="#">Long Term Acute Care Hospital (LTACH) MP9669 (III-INP.04)</a>	Required	Prior authorization required for admission and continued stay.	NA	NA
<a href="#">Lung Transplantation MP9615 (III-TRA.11)</a>	<a href="#">Lung Transplantation MP9615 (III-TRA.11)</a>	Required	Prior authorization is required for evaluation and actual transplant. 0494T, 0495T, 0496T, S2060, S2061, 32850, 32851, 32852, 32853, 32854, 32855, 32856.	NA	NA
<a href="#">Magnetic Esophageal Ring for the Treatment of Gastric Reflux Disease MP9471</a>	<a href="#">Magnetic Esophageal Ring for the Treatment of Gastric Reflux Disease MP9471</a>	Required	43284	NA	NA



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<a href="#">Male Gynecomastia Surgery MP9581 (iii-SUR.31)</a>	<a href="#">Male Gynecomastia Surgery MP9581 (iii-SUR.31)</a>	Required	19300	NA	NA
<a href="#">Mechanical Circulatory Support Devices MP9528</a>	<a href="#">Mechanical Circulatory Support Devices MP9528</a>	Not required	NA	Use applicable CPT or HCPCS codes	NA
<a href="#">Mechanical Stretching Devices for the Treatment of Joint Contractures of the Extremities MP9659</a>	<a href="#">Mechanical Stretching Devices for the Treatment of Joint Contractures of the Extremities MP9659</a>	Not covered	NA	NA	E0935, E0936, E1800, E1801, E1802, E1803, E1805, E1806, E1810, E1811, E1812, E1815, E1816, E1818, E1820, E1821, E1825, E1830, E1831, E1840, E1841
<a href="#">Mechanized Spinal Decompression Traction Tables for Low Back Pain MP9644</a>	<a href="#">Mechanized Spinal Decompression Traction Tables for Low Back Pain MP9644</a>	Not covered	NA	NA	E0941
<a href="#">Meibomian Gland Evacuation Therapies MP9719</a>	<a href="#">Meibomian Gland Evacuation Therapies MP9719</a>	Not covered	NA	NA	0207T, 0563T
<a href="#">Microprocessor Controlled Knee Prostheses, With or Without Polycentric, Three-Dimensional</a>	<a href="#">Microprocessor Controlled Knee Prostheses, With or Without Polycentric, Three-Dimensional</a>	Required	L5856, L5857, L5858, L5859, L5930, L5961, L5962	NA	NA





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<a href="#">Endoskeletal Hip Joint System MP9638</a>	<a href="#">Endoskeletal Hip Joint System MP9638</a>				
<a href="#">mild® Procedure (mild® Device Kit) MP9761</a>	<a href="#">mild® Procedure (mild® Device Kit) MP9761</a>	Not covered	NA	NA	0275T
<a href="#">Minced Cartilage (Allograft) Repair for Articular Cartilage Defects MP9762</a>	<a href="#">Minced Cartilage (Allograft) Repair for Articular Cartilage Defects MP9762</a>	Not covered	NA	NA	27415, 29867
<a href="#">Motion Preserving Posterior Inter-spinous/Inter-laminar Decompression/Stabilization Devices MP9749</a>	<a href="#">Motion Preserving Posterior Inter-spinous/Inter-laminar Decompression/Stabilization Devices MP9749</a>	Not covered	NA	NA	22867, 22868, 22869, 22870, C1821
<a href="#">Multichannel Intraluminal Esophageal Impedance with pH Monitoring MP9567</a>	<a href="#">Multichannel Intraluminal Esophageal Impedance with pH Monitoring MP9567</a>	Not required	NA	Use applicable CPT or HCPCS codes	NA
<a href="#">Musculoskeletal Procedures, Interventional Pain Management -</a>	<a href="#">Musculoskeletal Procedures, Interventional Pain Management -</a>	Required through Carelon for these services: <ul style="list-style-type: none"> <li>Epidural Injection Procedure</li> </ul>	27096, 62280, 62281, 62282, 62292, 62320, 62321, 62322, 62323, 62324, 62325, 62326, 62327, 63650, 63655, 63663, 63664, 63685,	NA	NA

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<p>See Carelton website: <a href="https://guidelines.careltonmedicalbenefitsmanagement.com/current-musculoskeletal-guidelines/">https://guidelines.careltonmedicalbenefitsmanagement.com/current-musculoskeletal-guidelines/</a></p> <p>Click <a href="#">here</a> for additional information regarding Carelton.</p> <p><b>Note:</b> Effective 10/01/2024, prior authorization for the services listed in the chart to the right will be submitted to Carelton.</p> <p>Procedures performed on an emergent basis (as part of being evaluated at the ER and prior to the patient's discharge from the hospital) are not included in the Carelton MSK program.</p>	<p>See Carelton website: <a href="https://guidelines.careltonmedicalbenefitsmanagement.com/current-musculoskeletal-guidelines/">https://guidelines.careltonmedicalbenefitsmanagement.com/current-musculoskeletal-guidelines/</a></p> <p>Click <a href="#">here</a> for additional information regarding Carelton.</p> <p><b>Note:</b> Effective 10/01/2024, prior authorization for the services listed in the chart to the right will be submitted to Carelton.</p> <p>Procedures performed on an emergent basis (as part of being evaluated at the ER and prior to the patient's discharge from the hospital) are not included in the Carelton MSK program.</p>	<p>s &amp;</p> <p>Diagnostic</p> <p>Selective</p> <p>Nerve</p> <p>Root</p> <p>Blocks</p> <ul style="list-style-type: none"> <li>Paravertebral Facet Injection/Medial Branch Nerve Block/Neurolysis (e.g., percutaneous denervation procedures)</li> <li>Regional Sympathetic Nerve Block</li> </ul>	<p>63688, 64451, 64479, 64480, 64483, 64484, 64490, 64491, 64492, 64493, 64494, 64495, 64510, 64520, 64625, 64628, 64629, 64633, 64634, 64635, 64636, 94493, G0260, 0213T, 0214T, 0215T, 0216T, 0217T, 0218T</p>		



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		<ul style="list-style-type: none"> <li>Sacroiliac Joint Injection</li> <li>Spinal Cord and Nerve Root Stimulators</li> </ul>			
Musculoskeletal Procedures, (Large) Joint Surgery  See Carelon website: <a href="https://guidelines.carelonmedicalbenefitsmanagement.com/current-musculoskeletal-guidelines/">https://guidelines.carelonmedicalbenefitsmanagement.com/current-musculoskeletal-guidelines/</a>  Click <a href="#">here</a> for additional information on Carelon prior authorization.  Note: Effective 10/01/2024, prior authorization for the services listed in the	Musculoskeletal Procedures, (Large) Joint Surgery <u>See Carelon website:</u> <a href="https://guidelines.carelonmedicalbenefitsmanagement.com/current-musculoskeletal-guidelines/">https://guidelines.carelonmedicalbenefitsmanagement.com/current-musculoskeletal-guidelines/</a> Click <a href="#">here</a> for additional information on Carelon prior authorization.  Note: Effective 10/01/2024, prior authorization for the services listed in the	Required through Carelon for these services:  <u>Hip</u> <ul style="list-style-type: none"> <li>Arthroplasty</li> <li>Arthroscopy &amp; Open Procedures</li> </ul> <u>Knee</u> <ul style="list-style-type: none"> <li>Arthroplasty</li> <li>Arthroscopy &amp; Open Procedures</li> <li>Autologous Chondrocyte</li> </ul>	23105, 23107, 23120, 23130, 23410, 23412, 23415, 23420, 23430, 23440, 23450, 23455, 23460, 23462, 23465, 23466, 23470, 23472, 23473, 23474, 23700, 27120, 27122, 27125, 27130, 27132, 27134, 27137, 27138, 27331, 27332, 27333, 27334, 27335, 27345, 27403, 27405, 27407, 27409, 27412, 27415, 27416, 27418, 27420, 27422, 27424, 27425, 27427, 27428, 27429, 27437, 27438, 27440, 27441, 27442, 27443, 27445, 27446, 27447, 27486, 27487, 27488, 27570, 28446, 29805, 29806, 29807, 29819, 29820, 29821, 29822, 29823, 29824, 29825, 29826, 29827, 29828, 29860, 29861, 29862, 29863, 29866, 29867, 29868, 29870, 29871, 29873, 29874,	NA	NA



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chart to the right will be submitted to Carelon.  Procedures performed on an emergent basis (as part of being evaluated at the ER and prior to the patient's discharge from the hospital) are not included in the Carelon MSK program.	chart to the right will be submitted to Carelon.  Procedures performed on an emergent basis (as part of being evaluated at the ER and prior to the patient's discharge from the hospital) are not included in the Carelon MSK program.	Implantation of the Knee  <u>Shoulder</u> • Arthroplasty • Arthroscopy & Open Procedures	29875, 29876, 29877, 29879, 29880, 29881, 29882, 29883, 29884, 29885, 29886, 29887, 29888, 29889, 29892, 29914, 29915, 29916, G0289, G0428, J7330, S2112, S2118, C9781		
Musculoskeletal Procedures, Spine  <u>See Carelon website:</u> <a href="https://guidelines.carelonmedicalbenefitsmanagement.com/current-musculoskeletal-guidelines/">https://guidelines.carelonmedicalbenefitsmanagement.com/current-musculoskeletal-guidelines/</a>  Click <a href="#">here</a> for additional information on Carelon prior authorization.  <u>Note:</u> Effective 10/01/2024, prior authorization for the	Musculoskeletal Procedures, Spine  <u>See Carelon website:</u> <a href="https://guidelines.carelonmedicalbenefitsmanagement.com/current-musculoskeletal-guidelines/">https://guidelines.carelonmedicalbenefitsmanagement.com/current-musculoskeletal-guidelines/</a>  Click <a href="#">here</a> for additional information on Carelon prior authorization.  <u>Note:</u> Effective 10/01/2024, prior authorization for the	Required through Carelon for these services:  <u>Cervical</u> • Decompression With/Without Fusion • Disc Arthroplasty  <u>Lumbar</u> • Discectomy, Foraminotomy & Laminotomy • Laminectomy • Fusion & Treatment of	20930, 20931, 20936, 20937, 20938, 20939, 22206, 22207, 22208, 22210, 22212, 22214, 22216, 22220, 22222, 22224, 22226, 22510, 22511, 22512, 22513, 22514, 22515, 22532, 22533, 22534, 22548, 22551, 22552, 22554, 22556, 22558, 22585, 22590, 22595, 22600, 22610, 22612, 22614, 22630, 22632, 22633, 22634, 22800, 22802, 22804, 22808, 22810, 22812, 22818, 22819, 22830, 22840, 22841, 22842, 22843, 22844, 22845, 22846, 22847, 22848, 22849, 22853, 22854, 22856, 22857, 22858, 22859, 22860, 22861, 22862, 22864, 22865, 27278, 27279, 27280, 62380, 63001, 63003, 63005, 63012, 63015, 63016, 63017,	NA	NA

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services listed in the chart to the right will be submitted to Carelon.  Procedures performed on an emergent basis (as part of being evaluated at the ER and prior to the patient's discharge from the hospital) are not included in the Carelon MSK program.	services listed in the chart to the right will be submitted to Carelon.  Procedures performed on an emergent basis (as part of being evaluated at the ER and prior to the patient's discharge from the hospital) are not included in the Carelon MSK program.	Spinal Deformity • Disc Arthroplasty • Posterolateral or Intertransverse Lumbar Fusion (autograft not feasible)  Sacroiliac Joint Fusion (Percutaneous/Minimally Invasive Techniques, Open)  Electrical Bone Growth Stimulation, Noninvasive_-spine  Vertebroplasty/Kyphoplasty	63020, 63030, 63035, 63040, 63042, 63043, 63044, 63045, 63046, 63047, 63048, 63050, 63051, 63052, 63053, 63055, 63056, 63057, 63075, 63076, 63081, 63082, 63085, 63086, 63087, 63088, 63090, 63091, 63101, 63102, 63103, 63185, 63190, 63191, 63200, 63250, 63252, 63265, 63267, 63270, 63272, 63275, 63277, 63280, 63285, 63287, 63290, 63300, 63301, 63302, 63303, 63304, 63305, 63306, 63307, 63308, C9359, C9362, C7504, C7505, C7507, C7508, E0748, 0095T, 0098T, 0164T, 0165T, 0200T, 0201T		



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		Bone Graft Substitutes and Bone Morphogenic Proteins  Anterior Lumbar Interbody Fusion (ALIF) or Lateral Lumbar Interbody Fusion (i.e., XLIF)			
<a href="#">Myocardial Strain Imaging (e.g., Cardiac Magnetic Resonance, Speckle Tracking Echocardiography, Tissue Doppler Echocardiography MP9771</a>	<a href="#">Myocardial Strain Imaging (e.g., Cardiac Magnetic Resonance, Speckle Tracking Echocardiography, Tissue Doppler Echocardiography MP9771</a>	Not covered	NA	NA	93356
<a href="#">Myoelectric Upper Limb Prosthetics and Orthotics MP9637</a>	<a href="#">Myoelectric Upper Limb Prosthetics and Orthotics MP9637</a>	Not required	NA	L6611, L6881, L6890, L6925, L6935, L6945, L6950, L6955, L6965, L6975, L6672, L6680, L6682, L6684, L6686, L6687, L6688, L6689, L6690, L7007, L7008,	L6026, L6715, L6880, L6882, L8701, L8702



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				L7009, L7045, L7180, L7181, L7190, L7191	
<a href="#">Nasal Expiratory Positive Airway Pressure (Provent) for Obstructive Sleep Apnea MP9753</a>	<a href="#">Nasal Expiratory Positive Airway Pressure (Provent) for Obstructive Sleep Apnea MP9753</a>	Not covered	NA	NA	A7049
<a href="#">Nasal Implant, Absorbable, for Treatment of Nasal Valve Collapse MP9773</a>	<a href="#">Nasal Implant, Absorbable, for Treatment of Nasal Valve Collapse MP9773</a>	Not covered	NA	NA	30468
<a href="#">Nebulized Intranasal Antibiotics/Antifungals for Sinusitis MP9712</a>	<a href="#">Nebulized Intranasal Antibiotics/Antifungals for Sinusitis MP9712</a>	Not covered	NA	NA	95199
<a href="#">Negative Pressure Wound Therapy with Installation System MP9720</a>	<a href="#">Negative Pressure Wound Therapy with Installation System MP9720</a>	Not covered	NA	NA	If a claim is submitted, the claim will deny unless coverage is mandated by state/federal laws.
<a href="#">Neurofeedback or Biofeedback for Behavioral and Substance Use Disorders MP9579</a>	<a href="#">Neurofeedback or Biofeedback for Behavioral and Substance Use Disorders MP9579</a>	Not required	NA	Use applicable CPT or HCPCS codes	NA





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<a href="#">Neuropsychological Testing MP9493</a>	<a href="#">Neuropsychological Testing MP9493</a>	Not required	NA	96121, 96132, 96133	NA
<a href="#">Noncontact, Low-frequency Ultrasound Therapy for Healing of Chronic Wounds MP9735</a>	<a href="#">Noncontact, Low-frequency Ultrasound Therapy for Healing of Chronic Wounds MP9735</a>	Not covered	NA	NA	97610
<a href="#">Noncontact Near Infrared Spectroscopy MP9780</a>	<a href="#">Noncontact Near Infrared Spectroscopy MP9780</a>	Not covered	NA	NA	Use applicable CPT or HCPCS codes
<a href="#">Non-Contact Normothermic Wound Therapy MP9721</a>	<a href="#">Non-Contact Normothermic Wound Therapy MP9721</a>	Not covered	NA	NA	0859T, 0860T, 0640T
<a href="#">Non-Covered Medical Procedures and Services MP9415</a> This policy indicates services which are considered either Experimental/Investigational (E/I) or Not Medically Necessary (NMN). Some MAY be considered for	<a href="#">Non-Covered Medical Procedures and Services MP9415</a> This policy indicates services which are considered either Experimental/Investigational (E/I) or Not Medically Necessary (NMN). Some MAY be considered for	Not covered	NA	NA	A6000, A6550, A6560, A9291, 0126T, 0200T, 0206T, 0263T, 0264T, 0265T, 0341T, 0397T, 0623T, 0657T, 0745T, 0746T, 0747T, 0776T, 0783T, C1824, C1825, C9772, C9773, C9774, C9775, C1062, E2120, E0769, C1825, 0627T, 0628T, 0629T, 0630T, C2624, C9724, C9757, 64625, 62263, 62264,





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coverage in specific situations. Review of the actual policy is needed to determine whether the procedure/service you are intending to request has been identified as E/I or NMN. *The list of codes is provided for informational purposes only and may not be all inclusive. Benefit coverage for any service is determined by the member's policy of health coverage.	coverage in specific situations. Review of the actual policy is needed to determine whether the procedure/service you are intending to request has been identified as E/I or NMN. *The list of codes is provided for informational purposes only and may not be all inclusive. Benefit coverage for any service is determined by the member's policy of health coverage.				93278, 0335T, 0639T, 0631T, 93025, 0596T, 0597T, S2348, 0219T, 0220T, 0221T, 0222T, 0266T, 0267T, 0268T, 0269T, 0270T, 0271T, 0272T, 0273T, 0510T, 0511T, S2117, 67999, 0624T, 0625T, 0658T, 0656T, 0659T, 0692T, 0693T, 0695T, 0696T, 17999, 20999, 22899, 27005, 27306, 27602, 30999, 31299, 33999, 38999, 55899, 69779, 97124, 97606, 97608, 92499, 92700, 97039, S9101, G2170, G2171
<a href="#">Non-invasive Measurement of Left Ventricular End Diastolic Pressure MP9767</a>	<a href="#">Non-invasive Measurement of Left Ventricular End Diastolic Pressure MP9767</a>	Not covered	NA	NA	93799
<a href="#">Non-pneumatic Compression Systems or Garments (e.g. Dayspring) MP9750</a>	<a href="#">Non-pneumatic Compression Systems or Garments (e.g. Dayspring) MP9750</a>	Not covered	NA	NA	E0678, E0679, E0680, E0681, E0682
<a href="#">Non-Powered or Single Use Negative</a>	<a href="#">Non-Powered or Single Use Negative</a>	Not covered	NA	NA	97607, 97608, A9272

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<a href="#">Pressure Wound Therapy Systems MP9784</a>	<a href="#">Pressure Wound Therapy Systems MP9784</a>				
<a href="#">Nutritional Counseling MP9661</a>	<a href="#">Nutritional Counseling MP9661</a>	Not required	NA	Use applicable CPT or HCPCS codes	NA
<a href="#">Orthognathic Surgery MP9651 (III-SUR.32)</a>	<a href="#">Orthognathic Surgery MP9651 (III-SUR.32)</a>	Required	21085, 21110, 21121, 21122, 21123, 21125, 21127, 21141, 21142, 21143, 21145, 21146, 21147, 21150, 21151, 21154, 21155, 21159, 21160, 21193, 21194, 21195, 21196, 21198, 21199, 21206, 21208, 21210, 21215, 21247, 21249, 21685, D7940, D7941, D7943, D7944, D7945, D7946, D7947, D7948, D7949, D7950, D7995, D7996	NA	NA
<a href="#">Outpatient and Inpatient Electroconvulsive Therapy (ECT) MP9570</a>	<a href="#">Outpatient and Inpatient Electroconvulsive Therapy (ECT) MP9570</a>	Not required	NA	90870	NA



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<a href="#">Outpatient Enteral Therapy MP9069</a>	<a href="#">Outpatient Enteral Therapy MP9069</a>	Required	B4102, B4103, B4104, B4149, B4150, B4152, B4153, B4154, B4155, B4157, B4158, B4159, B4160, B4161, B4162	NA	B4105
<a href="#">Palatal Implants for Obstructive Sleep Apnea MP9754</a>	<a href="#">Palatal Implants for Obstructive Sleep Apnea MP9754</a>	Not covered	NA	NA	C9757
<a href="#">Pancreas-Kidney (SPK, PAK) Transplantation MP9617</a>	<a href="#">Pancreas-Kidney (SPK, PAK) Transplantation MP9617</a>	Required	Prior authorization is needed for evaluation and actual transplant. S2065	NA	NA
<a href="#">Pancreas Transplantation (Pancreas Alone) MP9616</a>	<a href="#">Pancreas Transplantation (Pancreas Alone) MP9616</a>	Required	Prior authorization is needed for evaluation and actual transplant. 48160, 48550, 48551, 48552, 48554, 48556, G0341, G0342, G0343, 0584T, 0585T, 0586T, S2102.	NA	NA
<a href="#">Partial Hospitalization Program (PHP) – Behavioral Health MP9555</a>	<a href="#">Partial Hospitalization Program (PHP) – Behavioral Health MP9555</a>	Not required	NA	Use applicable CPT or HCPCS codes	NA
<a href="#">Pelvic Vein Embolization MP9572</a>	<a href="#">Pelvic Vein Embolization MP9572</a>	Not covered	NA	NA	If a claim is submitted, the claim will deny

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					unless coverage is mandated by state/federal laws.
<a href="#">Percutaneous Disc Decompression Procedures (Percutaneous Discectomies, Nucleoplasty) MP9734</a>	<a href="#">Percutaneous Disc Decompression Procedures (Percutaneous Discectomies, Nucleoplasty) MP9734</a>	Not covered	NA	NA	62287, S2348
<a href="#">Percutaneous Neuromodulation Therapy for the Treatment of Pain MP9724</a>	<a href="#">Percutaneous Neuromodulation Therapy for the Treatment of Pain MP9724</a>	Not covered	NA	NA	If a claim is submitted, the claim will deny unless coverage is mandated by state/federal laws.
<a href="#">Percutaneous Tibial Nerve Stimulation MP9563</a>	<a href="#">Percutaneous Tibial Nerve Stimulation MP9563</a>	Not required	NA	Use applicable CPT or HCPCS codes	NA
<a href="#">Percutaneous Ultrasonic Ablation of Soft Tissue MP9725</a>	<a href="#">Percutaneous Ultrasonic Ablation of Soft Tissue MP9725</a>	Not covered	NA	NA	If a claim is submitted, the claim will deny unless coverage is mandated by state/federal laws.
<a href="#">Photodynamic Therapy with Visudyne®(verteprofin)</a>	<a href="#">Photodynamic Therapy with Visudyne®(verteprofin)</a>	Not required	NA	Use applicable CPT or HCPCS codes	NA

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<a href="#">for Ocular Indications MP9660</a>	<a href="#">for Ocular Indications MP9660</a>				
<a href="#">Phrenic Nerve Stimulation for Central Sleep Apnea MP9755</a>	<a href="#">Phrenic Nerve Stimulation for Central Sleep Apnea MP9755</a>	Not covered	NA	NA	If a claim is submitted, the claim will deny unless coverage is mandated by state/federal laws.
<a href="#">Powered Robotic Lower-Limb Exoskeleton Devices MP9645</a>	<a href="#">Powered Robotic Lower-Limb Exoskeleton Devices MP9645</a>	Not covered	NA	NA	A4541, L2006
<a href="#">Prolotherapy MP9726</a>	<a href="#">Prolotherapy MP9726</a>	Not covered	NA	NA	M0076
<a href="#">Quantitative Electroencephalogram (qEEG) and Referenced Electroencephalogram (rEEG) MP9622</a>	<a href="#">Quantitative Electroencephalogram (qEEG) and Referenced Electroencephalogram (rEEG) MP9622</a>	Not required	NA	Use applicable CPT or HCPCS codes	NA
<a href="#">Quantitative Sensory Tests MP9727</a>	<a href="#">Quantitative Sensory Tests MP9727</a>	Not covered	NA	NA	0106T, 0107T, 0108T, 0109T, 0110T, G0255



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<p>Radiology Services -</p> <p><u>See Carelon website:</u> <a href="https://guidelines.carelonmedicalbenefitsmanagement.com/current-radiology-guidelines/">https://guidelines.carelonmedicalbenefitsmanagement.com/current-radiology-guidelines/</a></p> <p>Click <a href="#">here</a> for additional information on Carelon prior authorization.</p> <p><b>Note:</b> Effective 10/01/2024, prior authorization for the services listed in the chart to the right will be submitted to Carelon.</p> <p>Procedures performed in an inpatient setting (i.e., those services performed during an inpatient stay) or on an emergent basis (i.e., those services performed as part of being evaluated at the ER and prior to the</p>	<p>Radiology Services -</p> <p><u>See Carelon website:</u> <a href="https://guidelines.carelonmedicalbenefitsmanagement.com/current-radiology-guidelines/">https://guidelines.carelonmedicalbenefitsmanagement.com/current-radiology-guidelines/</a></p> <p>Click <a href="#">here</a> for additional information on Carelon prior authorization.</p> <p><b>Note:</b> Effective 10/01/2024, prior authorization for the services listed in the chart to the right will be submitted to Carelon.</p> <p>Procedures performed in an inpatient setting (i.e., those services performed during an inpatient stay) or on an emergent basis (i.e., those services performed as part of being evaluated at the ER and prior to the</p>	<p>Required through Carelon for these services:</p> <p>Selected applications of the following:</p> <ul style="list-style-type: none"> <li>• Computed tomography (CT)</li> <li>• Low-dose CT</li> <li>• Magnetic resonance imaging (MRI)</li> <li>• Functional MRI</li> <li>• Magnetic resonance spectroscopy</li> <li>• Magnetic resonance cholangiopanc reatography (MRCP)</li> <li>• Positron emission</li> </ul>	<p>70336, 70450, 70460, 70470, 70480, 70481, 70482, 70486, 70487, 70488, 70490, 70491, 70492, 70496, 70498, 70540, 70542, 70543, 70544, 70545, 70546, 70547, 70548, 70549, 70551, 70552, 70553, 70554, 70555, 71250, 71260, 71270, 71271, 71275, 71550, 71551, 71552, 71555, 72125, 72126, 72127, 72128, 72129, 72130, 72131, 72132, 72133, 72141, 72142, 72146, 72147, 72148, 72149, 72156, 72157, 72158, 72159, 72191, 72192, 72193, 72194, 72195, 72196, 72197, 72198, 73200, 73201, 73202, 73206, 73218, 73219, 73220, 73221, 73222, 73223, 73225, 73700, 73701, 73702, 73706, 73718, 73719, 73720, 73721, 73722, 73723, 73725, 74150, 74160, 74170, 74174, 74175, 74176, 74177, 74178, 74181, 74182, 74183, 74185, 74261, 74262, 74263, 74712, 75557, 75559, 75561, 75563, 75571, 75572, 75573, 75574, 75580, 75635, 76390, 76391, 77046, 77047, 77048, 77049, 77078, 77084, 78429, 78430, 78431, 78432, 78433, 78451, 78452, 78453, 78454, 78459, 78466,</p>		

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patient's discharge from the hospital) are not included in the Carelon radiology program.	patient's discharge from the hospital) are not included in the Carelon radiology program.	tomography (PET) <ul style="list-style-type: none"> <li>• CT or MR arthrography</li> <li>• Low-field MRI</li> <li>• MR-guided Procedures</li> <li>• Nuclear Medicine Imaging</li> <li>• Oncologic Imaging</li> <li>• SPECT Imaging</li> <li>• Vascular Imaging</li> </ul>	78468, 78469, 78472, 78473, 78481, 78483, 78491, 78492, 78494, 78608, 78609, 78811, 78812, 78813, 78814, 78815, 78816, 0042T, 0633T, 0634T, 0635T, 0636T, 0637T, 0638T, 0648T, S8037, S8042, S8092		
<a href="#">Radioembolization of Hepatic Tumors MP9774</a>	<a href="#">Radioembolization of Hepatic Tumors MP9774</a>	Not required	NA	Use applicable CPT or HCPCS codes	NA
<a href="#">Radiofrequency Ablation of Uterine Fibroids MP9657</a>	<a href="#">Radiofrequency Ablation of Uterine Fibroids MP9657</a>	Not required	NA	Use applicable CPT or HCPCS codes	NA
<a href="#">Radiofrequency Spectroscopy for Intra-Operative Assessment of Surgical Margins in</a>	<a href="#">Radiofrequency Spectroscopy for Intra-Operative Assessment of Surgical Margins in</a>	Not covered	NA	NA	0546T





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<a href="#">Breast Cancer (e.g., MarginProbe) MP9792</a>	<a href="#">Breast Cancer (e.g., MarginProbe) MP9792</a>				
<a href="#">Radiofrequency Volumetric Tissue Reduction for Obstructive Sleep Apnea MP9751</a>	<a href="#">Radiofrequency Volumetric Tissue Reduction for Obstructive Sleep Apnea MP9751</a>	Not covered	NA	NA	41530
<a href="#">Real-Time Mobile Cardiac Outpatient Telemetry MP9621</a>	<a href="#">Real-Time Mobile Cardiac Outpatient Telemetry MP9621</a>	Required	93228, 93229	NA	NA
<a href="#">Remote Patient Monitoring (RPM) and Remote Therapeutic Monitoring (RTM) MP9716</a>	<a href="#">Remote Patient Monitoring (RPM) and Remote Therapeutic Monitoring (RTM) MP9716</a>	Not required	NA	99091, 99453, 99454, 99457, 99458, 99474, G0322	98975, 98976, 98977, 98978, 98980, 98981
<a href="#">Repairs/Replacement of Durable Medical Equipment/Supplies MP9106</a>	<a href="#">Repairs/Replacement of Durable Medical Equipment/Supplies MP9106</a>	Not required	NA	K0672, L4010, L4020, L4030, L4130, L8514, L8681, L8684, L8689, L8691	A4233, A4234, A4235, A4236, A1366, A4634, A4638, A4639, A8004, L7367, L7368, L7902, V5336
<a href="#">Residential Treatment – Behavioral Health MP9554</a>	<a href="#">Residential Treatment – Behavioral Health MP9554</a>	Required	Prior authorization is required for residential treatment. See medical policy for criteria.	NA	NA





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<a href="#">Sacral Nerve Stimulation MP9624</a>	<a href="#">Sacral Nerve Stimulation MP9624</a>	Not required	NA	Use applicable CPT or HCPCS codes	NA
<a href="#">Salivary Estriol Test for Preterm Labor MP9682</a>	<a href="#">Salivary Estriol Test for Preterm Labor MP9682</a>	Not covered	NA	NA	S3652
<a href="#">Salivary Hormone Tests MP9683</a>	<a href="#">Salivary Hormone Tests MP9683</a>	Not covered	NA	NA	S3650
<a href="#">Scanning Laser Technologies for Retina and Optic Nerve Imaging MP9629</a>	<a href="#">Scanning Laser Technologies for Retina and Optic Nerve Imaging MP9629</a>	Not required	NA	0604T, 0605T, 0606T, 92133, 92134, 92201, 92202	NA
<a href="#">Scar Revision MP9649</a>	<a href="#">Scar Revision MP9649</a>	Not required	NA	Use applicable CPT or HCPCS codes	NA
<a href="#">Scrambler Pain Therapy MP9728</a>	<a href="#">Scrambler Pain Therapy MP9728</a>	Not covered	NA	NA	0278T
<a href="#">Sensory and Auditory Integration Therapies MP9729</a>	<a href="#">Sensory and Auditory Integration Therapies MP9729</a>	Not covered	NA	NA	97533



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<a href="#">Serial Dilution Endpoint Titration for Diagnosis and Treatment of Airborne Allergy MP9684</a>	<a href="#">Serial Dilution Endpoint Titration for Diagnosis and Treatment of Airborne Allergy MP9684</a>	Not covered	NA	NA	95027
<a href="#">Services Related to Dental Care MP9271</a>	<a href="#">Services Related to Dental Care MP9271</a>	Not required	NA	Use applicable CPT or HCPCS codes	NA
<a href="#">Single Photon Emission Computed Tomography (SPECT) for Attention Deficit Hyperactivity Disorder (ADHD) MP9633</a>	<a href="#">Single Photon Emission Computed Tomography (SPECT) for Attention Deficit Hyperactivity Disorder (ADHD) MP9633</a>	Not covered	NA	NA	If a claim is submitted, the claim will deny unless coverage is mandated by state/federal laws.
<a href="#">Skilled Nursing Facility MP9670</a>	<a href="#">Skilled Nursing Facility MP9670</a>	Required	Prior authorization required for admission and continued stay.	NA	NA
<a href="#">Skin and Soft Tissue Engineered Substitutes for Wound and Surgical Care MP9655</a>	<a href="#">Skin and Soft Tissue Engineered Substitutes for Wound and Surgical Care MP9655</a>	Not required	NA	Q4101, Q4102, Q4103, Q4104, Q4105, Q4106, Q4107, Q4108, Q4112, Q4114, Q4116, Q4121, Q4122, Q4130, Q4132, Q4134, Q4151, Q4182,	Q4100, Q4113, Q4114, Q4115, Q4117, Q4118, Q4123, Q4126, Q4127, Q4128, Q4133, Q4135, Q4136, Q4137, Q4138, Q4139, Q4142, Q4143, Q4145, Q4146, Q4153, Q4157, Q4160, Q4161, Q4162, Q4163, Q4164, Q4165, Q4166, Q4167, Q4169, Q4171, Q4173,

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				Q4186, 15271, 15272, 15273, 15274, 15275, 15276, 15277, 15278, 15777	Q4174, Q4175, Q4176, Q4177, Q4178, Q4179, Q4180, Q4184, Q4185, Q4189, Q4190, Q4191, Q4192, Q4195, Q4196, Q4197, Q4181, Q4183, Q4193, Q4198, Q4201, Q4203, Q4204, Q4205, Q4206, Q4208, Q4209, Q4210, Q4211, Q4212, Q4213, Q4214, Q4215, Q4217, Q4218, Q4219, Q4220, Q4222, Q4226, Q4227, Q4229, Q4230, Q4231 Q4232 Q4233, Q4234, Q4235, Q4236 Q4237 Q4238, Q4240, Q4241, Q4242, Q4244, Q4245, Q4246, Q4247, Q4248, Q4250 Q4252 Q4253 Q4255, Q4166 Q4170 Q4188 Q4195, Q4196, Q4197, Q4215 Q4245 Q4247 Q4251 C9250 C9352, C9353, C9361, C9364, Q4137 Q4227 Q4242 Q4276, Q4277, Q4278, Q4281, Q4282, Q4283, Q4284, Q4311, Q4312, Q4313, Q4314, Q4315, Q4316, Q4317, Q4318, Q4319, Q4320, Q4321, Q4322,



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					Q4323, Q4324, Q4325, Q4326, Q4327, Q4328, Q4329, Q4330, Q4331, Q4332, Q4333, C1762, C1763, C1781 C9250, C9354 C9355 C9356 C9358 C9360 C9361, C9364, C9399, A4649
<a href="#">Sleep Studies for the Initial Diagnosis of Obstructive Sleep Apnea (OSA) MP9673</a>	<a href="#">Sleep Studies for the Initial Diagnosis of Obstructive Sleep Apnea (OSA) MP9673</a>	Required Prior authorization <b>is</b> required for in lab sleep studies for members older than 18 years of age. Prior Authorization <b>is not</b> required for Home-based studies OR for facility based studies for members less than 18 years of age.	95807, 95808, 95810, 95811	NA	NA
<a href="#">Sphenopalatine Ganglion Block for the Treatment of Headache MP9764</a>	<a href="#">Sphenopalatine Ganglion Block for the Treatment of Headache MP9764</a>	Not covered	NA	NA	64505



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<a href="#">Stem Cell and Cellular Bone Matrix Products for Orthopedic Applications MP9758</a>	<a href="#">Stem Cell and Cellular Bone Matrix Products for Orthopedic Applications MP9758</a>	Not covered	NA	NA	0565T, 0566T, 0627T, 0628T, 0629T, 0630T, 20939
<a href="#">Stem Cell Therapy for Peripheral Artery Disease MP9730</a>	<a href="#">Stem Cell Therapy for Peripheral Artery Disease MP9730</a>	Not covered	NA	NA	0263T, 0264T, 0265T
<a href="#">Subacromial Tissue Spacer for Treatment of Rotator Cuff MP9731</a>	<a href="#">Subacromial Tissue Spacer for Treatment of Rotator Cuff MP9731</a>	Not covered	NA	NA	C9781
<a href="#">Surgical and Minimally Invasive Treatments for Benign Prostatic Hypertrophy/Hyperplasia (BPH) MP9361</a>	<a href="#">Surgical and Minimally Invasive Treatments for Benign Prostatic Hypertrophy/Hyperplasia (BPH) MP9361</a>	Not required	NA	Use applicable CPT or HCPCS codes	0421T, 55880, 0619T, 0867T C2586 when billed with diagnosis code N400 or N401
<a href="#">Surgical Interruption of Pelvic Nerve Pathways for Treatment of Pelvic Pain MP9732</a>	<a href="#">Surgical Interruption of Pelvic Nerve Pathways for Treatment of Pelvic Pain MP9732</a>	Not covered	NA	NA	58578
<a href="#">Synthetic Cartilage Implants for First Metatarsal Phalangeal Joint MP9778</a>	<a href="#">Synthetic Cartilage Implants for First Metatarsal Phalangeal Joint MP9778</a>	Not covered	NA	NA	20291, L8641, L8642



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<a href="#">Synthetic Ceramic-Based and Bioactive Glass Bone MP9787</a>	<a href="#">Synthetic Ceramic-Based and Bioactive Glass Bone MP9787</a>	Not covered	NA	NA	A2002, C9359, C9362, 0707T
<a href="#">Technology Assisted Surgical Techniques (Robotic Surgery) MP9546</a>	<a href="#">Technology Assisted Surgical Techniques (Robotic Surgery) MP9546</a>	Not required Additional reimbursement is not provided based upon the type of instruments, technique, or approach (e.g. open, laparoscopic, percutaneous, endoscopic, thoracoscopy, and other/unspecified robotic assisted procedures).	NA	Use applicable CPT or HCPCS codes	NA
<a href="#">Telehealth MP9662</a>	<a href="#">Telehealth MP9662</a>	Not required	NA	Use applicable CPT or HCPCS codes	NA
<a href="#">Testing for Neutralizing Antibodies to Interferon Beta in Management of</a>	<a href="#">Testing for Neutralizing Antibodies to Interferon Beta in Management of</a>	Not covered	NA	NA	If a claim is submitted, the claim will deny unless coverage is mandated by state/federal laws.



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<a href="#">Multiple Sclerosis MP9685</a>	<a href="#">Multiple Sclerosis MP9685</a>				
<a href="#">Therapeutic Apheresis (TA) – Plasmapheresis, Plasma Exchange MP9627</a>	<a href="#">Therapeutic Apheresis (TA) – Plasmapheresis, Plasma Exchange MP9627</a>	Not required	NA	Use applicable CPT or HCPCS codes	NA
<a href="#">Thermography MP9733</a>	<a href="#">Thermography MP9733</a>	Not covered	NA	NA	93740
<a href="#">Thoracic Electrical Bioimpedance (TEB) for Cardiac Output Measurement MP9737</a>	<a href="#">Thoracic Electrical Bioimpedance (TEB) for Cardiac Output Measurement MP9737</a>	Not covered	NA	NA	97301
<a href="#">Three Dimensional (3-D) Printed Anatomic Modeling for Surgical Planning MP9738</a>	<a href="#">Three Dimensional (3-D) Printed Anatomic Modeling for Surgical Planning MP9738</a>	Not covered	NA	NA	0559T, 0560T, 0561T, 0562T
<a href="#">Tidal Knee Lavage for Osteoarthritis MP9739</a>	<a href="#">Tidal Knee Lavage for Osteoarthritis MP9739</a>	Not covered	NA	NA	If a claim is submitted, the claim will deny unless coverage is mandated by state/federal laws.



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<a href="#">Tongue Based Suspension Surgery MP9752</a>	<a href="#">Tongue Based Suspension Surgery MP9752</a>	Not covered	NA	NA	41512
<a href="#">Total Ankle Replacement MP9363</a>	<a href="#">Total Ankle Replacement MP9363</a>	Not required	NA	Use applicable CPT or HCPCS codes	NA
<a href="#">Transcatheter Closure of Cardiac Defects MP9625</a>	<a href="#">Transcatheter Closure of Cardiac Defects MP9625</a>	Not required	NA	Use applicable CPT or HCPCS codes	NA
<a href="#">Transcatheter Heart Valve Replacement and Repair Procedure MP9623</a>	<a href="#">Transcatheter Heart Valve Replacement and Repair Procedure MP9623</a>	Not required	NA	Use applicable CPT or HCPCS codes	0569T
<a href="#">Transcranial Magnetic Stimulation MP9526</a>	<a href="#">Transcranial Magnetic Stimulation MP9526</a>	Not required	NA	Use applicable CPT or HCPCS codes	NA
<a href="#">Transcutaneous Electrical Joint Stimulation Device MP9740</a>	<a href="#">Transcutaneous Electrical Joint Stimulation Device MP9740</a>	Not covered	NA	NA	E0762
<a href="#">Transvaginal and Transurethral Radiofrequency (RF) Treatments of Stress</a>	<a href="#">Transvaginal and Transurethral Radiofrequency (RF) Treatments of Stress</a>	Not covered	NA	NA	53860





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<a href="#">Urinary Incontinence in Women MP9741</a>	<a href="#">Urinary Incontinence in Women MP9741</a>				
<a href="#">Trigger Point Dry Needling MP9672</a>	<a href="#">Trigger Point Dry Needling MP9672</a>	Not covered	NA	NA	20560, 20561
<a href="#">Upright Magnetic Resonance Imaging (MRI) (Standing/Seated/Weight Bearing/Positional MRI) MP9742</a>	<a href="#">Upright Magnetic Resonance Imaging (MRI) (Standing/Seated/Weight Bearing/Positional MRI) MP9742</a>	Not covered	NA	NA	76498
<a href="#">Urine Drug Testing (UDT) Presumptive and Definitive MP9460</a>	<a href="#">Urine Drug Testing (UDT) Presumptive and Definitive MP9460</a>	Not required	NA	Use applicable CPT or HCPCS codes	NA
<a href="#">Urethral Bulking Agents for Urinary Incontinence MP9475</a>	<a href="#">Urethral Bulking Agents for Urinary Incontinence MP9475</a>	Not required	NA	Use applicable CPT or HCPCS codes	NA
<a href="#">Uvulopalatoplasty (UP2), UPP) and Laser-Assisted Uvulopalatoplasty (LAUP) for Sleep-Related Breathing Disorders MP9789</a>	Uvulopalatoplasty (UP2), UPP) and Laser-Assisted Uvulopalatoplasty (LAUP) for Sleep-Related Breathing Disorders MP9789	Not covered	NA	NA	If a claim is submitted, the claim will deny unless coverage is mandated by state/federal laws.



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<a href="#">Uvulopalatopharyngoplasty (UPPP or U3P) for Obstructive Sleep Apnea/Hypopnea Syndrome MP9775</a>	<a href="#">Uvulopalatopharyngoplasty (UPPP or U3P) for Obstructive Sleep Apnea/Hypopnea Syndrome MP9775</a>	Required	S2080	NA	NA
<a href="#">Vaginal Tactile Imaging MP9743</a>	<a href="#">Vaginal Tactile Imaging MP9743</a>	Not covered	NA	NA	0487T
Vagus Nerve Stimulation (VNS), Implantable MP9232	Vagus Nerve Stimulation (VNS), Implantable MP9232	Required	64533, 64568	NA	0312T, 0313T, 0314T, 0315T, 0316T, 0317T, K1020
<a href="#">Vein Disease Treatment MP9241</a>	<a href="#">Vein Disease Treatment MP9241</a>	Required	36465, 36466, 36470, 36471, 36473, 36474, 36475, 36476, 36478, 36479, 36482, 36483, 37500, 37700, 37718, 37722, 37735, 37760, 37761, 37765, 37766, 37780, 37785, 0524T	NA	36468
<a href="#">Vestibular Evoked Myogenic Potentials (VEMP) MP9744</a>	<a href="#">Vestibular Evoked Myogenic Potentials (VEMP) MP9744</a>	Not covered	NA	NA	92517, 92518, 92519
<a href="#">Virtual Care MP9663</a>	<a href="#">Virtual Care MP9663</a>	Not required	NA	Use applicable CPT or HCPCS codes	NA



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<a href="#">Vitamin D Testing for Screening MP9686</a>	<a href="#">Vitamin D Testing for Screening MP9686</a>	Not covered	NA	NA	82306, 82652, 0038U
<a href="#">VivAer Airway Remodeling for Airway Obstruction MP9745</a>	<a href="#">VivAer Airway Remodeling for Airway Obstruction MP9745</a>	Not covered	NA	NA	If a claim is submitted, the claim will deny unless coverage is mandated by state/federal laws.
<a href="#">Volara Oscillation and Lung Expansion System MP9746</a>	<a href="#">Volara Oscillation and Lung Expansion System MP9746</a>	Not covered	NA	NA	If a claim is submitted, the claim will deny unless coverage is mandated by state/federal laws.
<a href="#">Wheelchairs, Scooters and Accessories MP9782 (III-DEV.25)</a>	<a href="#">Wheelchairs, Scooters and Accessories MP9782 (III-DEV.25)</a>	Required	Purchase of all wheelchair and scooter codes require prior authorization. Prior authorization is required for wheelchair and scooter accessories, repairs or modifications with a billed charge of \$1,000 or more per item. Replacement of a wheelchair or scooter with another wheelchair or a	Rental does not require prior authorization and is allowed for 12 months or until 100% of purchase price has been reached. Rental of medically necessary equipment while the member's own equipment is being repaired does	A back up manual wheelchair for members with a powered device is considered a duplicate device and/or convenience item and is excluded from coverage.



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			different device requires prior authorization.	not require prior authorization.	
<a href="#">Wilderness Programs MP9723</a>	<a href="#">Wilderness Programs MP9723</a>	Not covered	NA	NA	T2036, T2037
<a href="#">Wireless Capsule Endoscopy (CE) and Capsule Technology to Verify Patency Prior to Capsule Endoscopy MP9626</a>	<a href="#">Wireless Capsule Endoscopy (CE) and Capsule Technology to Verify Patency Prior to Capsule Endoscopy MP9626</a>	Not required	NA	96110, 0651T	NA
<a href="#">Wireless Pulmonary Artery Pressure Monitoring Systems for Monitoring Heart Failure (CardioMEMS) MP9748</a>	<a href="#">Wireless Pulmonary Artery Pressure Monitoring Systems for Monitoring Heart Failure (CardioMEMS) MP9748</a>	Not covered	NA	NA	33289, 93264
<a href="#">Wound Imaging and Measuring Systems for Managing Chronic Wounds (e.g. Fluorescent Wound Imaging; Camera Wound Imaging) MP9783</a>	<a href="#">Wound Imaging and Measuring Systems for Managing Chronic Wounds (e.g. Fluorescent Wound Imaging; Camera Wound Imaging) MP9783</a>	Not covered	NA	NA	0598T, 0559T