



**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.**

## **Prevea360 Health Plan Master Service List (MSL)**



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### **General Information**

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.

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 Prevea360 Health Plan Customer Care Center at the appropriate number below:

- Prevea360 Individual + Family Business [IFB]/Affordable Care Act [ACA] plans: 1 (800) 458-5512
- Prevea360 Commercial plans: 1 (877) 230-7555

The [complete library of medical policies](#) is available on [Prevea360.com](https://www.Prevea360.com).



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## Submission Information

### Prevea360 Health Plan Commercial Insurance

- Providers are responsible for submitting prior authorizations for Prevea360 Health Plan Commercial members with **HMO** or **POS (In-Network Provider)** plans; and
- Prevea360 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 [Availability Essentials Portal](#).
- Prior Authorization Forms may be accessed by clicking [here](#).

### Dean Health Plan Administrative Services Only (ASO)

- ASO members – contracted Dean ASO & Prevea360 providers are responsible for submitting prior authorizations for Dean Health Plan ASO members.
- For all other providers, Dean 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 Dean 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 Customer Service at 877-234-4516
- 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: [DeanCare.com/Providers/Medical-Management](https://DeanCare.com/Providers/Medical-Management).

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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 Prevea360 Health Plan Commercial members with HMO or POS (In-Network Provider) plans.
- Prevea360 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.
- If the column states: Use applicable CPT or HCPCS codes, there are no specific CPT codes we can list because a general or nonspecific code applies.

#### **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.
- If the column states: Use applicable CPT or HCPCS codes, there are no specific CPT codes we can list because a general or nonspecific code applies.

#### **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.

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- If a claim is submitted the claim will deny unless coverage is mandated by state/federal laws. This **service** is investigative but there are no specific CPT codes we can list in the "Not Covered" column because a general or nonspecific code applies.
- 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 Prevea360 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 Prevea360.com](https://www.prevea360.com/medical-management);
- 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 Prevea360 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 Prevea360 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 Prevea360 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>	Prevea360 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 Prevea360 Health Plan provider network are considered for approval with a non-contracted provider.

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## **Carelon Prior Authorization**

Prevea360 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 Prevea360 Health Plan product lines:
  - Commercial –HMO/POS/PPO
  - Prevea360 Individual and Family Business
  - Dean Administrative Services Only (ASO)
  - Prevea360 Advantage

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<a href="#">Abdominoplasty/ Panniculectomy MP9646</a>	Required	15830, 15839, 15847	NA	NA
<a href="#">Actigraphy MP9559</a>	Not Required	NA	95803	NA
<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>	Not covered	NA	NA	If a claim is submitted, the claim will deny unless coverage is mandated by state/federal laws.
<a href="#">Allogenic Pancreatic Islet Cell Transplantation MP9756</a>	Not Covered	NA	NA	G0341, G0342, G0343, 0584T, 0585T, 0586T
<a href="#">Amino Acid-Based Elemental Formulas MP9355</a>	Not Required	NA	B4153, B4161	NA
<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>	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>	Not covered	NA	NA	95905
<a href="#">Bariatric Surgery MP9319</a>	Required	43644, 43645 only requires a prior authorization if related to bariatric surgery or when performed for weight management, 43770, 43771, 43772, 43773, 43775, 43842, 43843, 43848, 43860, 43865, 43886, 43887, 43888	NA	43290, 43291, 0312T
<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) and Bioelectrical Impedance Analysis (BIA) MP9690</a>	Not covered	NA	NA	93702, 0358T
<a href="#">Birth Centers (Free-Standing) MP9666</a>	Not required	NA	Use applicable CPT or HCPCS codes	NA
<a href="#">Blepharoplasty, Blepharoptosis Repair, and Brow Lift MP9664</a>	Required	15820, 15821, 15822, 15823, 67900, 67901, 67902, 67903, 67904, 67906, 67908, 67909	NA	NA

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<a href="#">Blood Coagulation Home Testing Devices MP9788</a>	Not required	NA	G0248, G0249, G0250	NA
<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>	Required	20974, 20975, 20979, E0747, E0748, E0749, E0760	NA	NA
<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, 38230, 38232, 38240, 38241, 38242, 38243, S2150	NA	NA
<a href="#">Breast Ductal Lavage MP9691</a>	Not covered	NA	NA	19499
<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	NA

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			such does not require prior authorization.	
<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>	Not covered	NA	NA	E0734
<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><u>See Carelon website -</u>  <a href="https://guidelines.carelonmedicalbenefitsmanagement.com/current-cardiology-guidelines/">https://guidelines.carelonmedicalbenefitsmanagement.com/current-cardiology-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</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,</p>	NA	NA

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the right will be submitted to Carelon.  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 program.		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		
<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>	Not required	NA	Use applicable CPT or HCPCS codes	0263T, 0264T, 0265T
<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>	Not required	NA	Use applicable CPT or HCPCS codes	NA

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<a href="#">Chronic Rhinitis: Cryoablation, Radiofrequency Ablation and Laser Ablation, Office-Based MP9631</a>	Not required	NA	Use applicable CPT or HCPCS codes	NA
<a href="#">CLEAR Institute Scoliosis Treatment Protocols MP9695</a>	Not covered	NA	NA	E1399
<a href="#">Clinical Trials (Clinical Trial Participation) MP9447</a>	Not required <small>**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.</small>	NA	Use applicable CPT or HCPCS codes	NA
<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>	Not covered	NA	NA	82523
<a href="#">Computerized Dynamic Posturography MP9696</a>	Not covered	NA	NA	92548, 92549
<a href="#">Confocal Laser Endomicroscopy for</a>	Not covered	NA	NA	43206, 43252, 0397T if billed with the following

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<a href="#">Barrett's Esophagus MP9697</a>				diagnosis codes: K227.10, K227.11, K227.19.
<a href="#">Corneal Cross-Linking (CXL) MP9470</a>	Not required	NA	Use applicable CPT or HCPCS codes	NA
<a href="#">Cranial Electrotherapy Stimulation (CES) MP9698</a>	Not covered	NA	NA	E0732, A4596
<a href="#">Craniosacral Therapy MP9699</a>	Not covered	NA	NA	97139
<a href="#">Cytotoxic Testing for Allergy Diagnosis MP9678</a>	Not covered	NA	NA	86807, 86808
<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>	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>	Not covered	NA	NA	S1091
<a href="#">Durable Medical Equipment MP9347</a>	Not required or Not covered	NA	A4670, 99473, 99474  *Please review policy to determine the criteria required for claims coverage of this service.	T2039, E0240, E0247, E0248, E0625, E0190, E0218, E0935, E0936, E0118, S9433, S9434, A4660, E0244, A9281, A4520, T4521, T4522, T4523, T4524, T4529, T4530, T4538, T4525, T4526, T4527, T4528,

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				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,  <small>*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.</small>
<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>	Not covered	NA	NA	64999, 13999

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<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>	Not covered	NA	NA	If a claim is submitted, the claim will deny unless coverage is mandated by state/federal laws.
<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>	Not required	NA	Use applicable CPT or HCPCS codes	NA
<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>	Not required	NA	Use applicable CPT or HCPCS codes	43257
<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>	Not covered	NA	NA	62263, 62264



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<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 Condensate pH Measurement MP9560</a>	Not required	NA	83987, 95012	NA
<a href="#">Extended Hours of Home Care (Private Duty Nursing) MP9673</a>	Required	Use applicable CPT or HCPCS codes	NA	NA
<a href="#">Extracorporeal Magnetic Stimulation for the Treatment of Urinary Incontinence MP9705</a>	Not covered	NA	NA	53899
<a href="#">Extracorporeal Photopheresis (Photochemotherapy) MP9558</a>	Not Required	NA	36522	NA
<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

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<a href="#">Eye-Movement Analysis without Spatial Calibration (e.g., EyeBOX® system) MP9785</a>	Not covered	NA	NA	0615T
<a href="#">Facility-Based Polysomnography, Adult (Sleep Study) MP9676</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>	Not required	NA	Use applicable CPT or HCPCS codes	NA
<a href="#">Female Breast Reduction Surgery – Reduction Mammoplasty MP9582</a>	Required	19318	NA	NA
<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>	Not required	NA	Use applicable CPT or HCPCS codes	86001
<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>	Not required	NA	Use applicable CPT or HCPCS codes	E0770, E0764

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<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>	Not covered	NA	NA	91112
<a href="#">Gender Affirmation Procedures MP9642</a>	Required	<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  <b>Procedures:</b> 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, 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,	NA	NA

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		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>	Not required	NA	Use applicable CPT or HCPCS codes	NA
<a href="#">Glaucoma Surgical Treatments (MP9467)</a>	Not required	NA	Use applicable CPT or HCPCS codes	NA
<a href="#">Hair Analysis in the Clinical Setting (MP9680)</a>	Not covered	NA	NA	P2031
<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,	V5266

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			V5247, V5248, V5249, V5250, V5251, V5252, V5253, V5254, V5255, V5256, V5257, V5258, V5259, V5260, V5261, V5262, V5263, V5298	
<a href="#">Heart\Lung Transplantation (MP9612)</a>	Required	33930, 33933, 33935. Prior authorization is needed for evaluation and actual transplant.	NA	NA
<a href="#">Heart Transplantation (Adult and Pediatric) (MP9613)</a>	Required	33940, 33944, 33945. Prior authorization is needed for evaluation and actual transplant.	NA	NA
<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>	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</a>	Not required	NA	21120, 21121, 21122, 21123, 21199, 42145, E0470, E0471, E0472, E0485, E0486, E0601, A9279	0437T, 64582, 64583, 64584

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<a href="#">Sleep Apnea (OSA) MP9658</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, 64583, 64584
<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>	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>	Not covered	NA	NA	If a claim is submitted, the claim will deny unless

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				coverage is mandated by state/federal laws.
<a href="#">Implantable Deep Brain Stimulation (DBS) MP9331</a>	Not required	NA	61885, 61886	NA
<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>	Required	64568, 64582	NA	41521
<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</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

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<a href="#">Inpatient Rehabilitation (Acute Rehabilitation) MP9668</a>	Required	Prior authorization required for admission and continued stay.	NA	NA
<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>	Not required	NA	Use applicable CPT or HCPCS codes	NA
<a href="#">Interferential Current Stimulation MP9710</a>	Not covered	NA	NA	S8130, S8131, E1399
<a href="#">Intestinal Transplantation MP9618</a>	Required	44132, 44133, 47133, 44135, 44136, 44137, 44715, 44720, 44721, 47135, 47140, 47141, 47142, 47143, 47144, 47145, 47146, 47147. Prior authorization is needed for evaluation and actual transplant.	NA	NA
<a href="#">Intradiscal Electrothermal (IDET) MP9711</a>	Not covered	NA	NA	22526, 22527
<a href="#">Intraoperative Neurophysiological Monitoring (IONM) MP9577</a>	Not required	NA	Use applicable CPT or HCPCS codes	NA



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<a href="#">Intravascular Shockwave Lithotripsy for the Treatment of Coronary Artery Disease MP9770</a>	Not covered	NA	NA	C1761, 92972
<a href="#">In Vitro Chemosensitivity and Chemoresistance Assays MP9760</a>	Not covered	NA	NA	0564T, 0083U
<a href="#">Iris Prosthesis MP9715</a>	Not covered	NA	NA	0616T, 0617T, 0618T, C1839
<a href="#">Irreversible Electroporation (NanoKnife System) MP9714</a>	Not covered	NA	NA	0600T, 0601T
<a href="#">Kidney Transplantation MP9675</a>	Required	50300, 50320, 50323, 50325, 50327, 50328, 50329, 50340, 50360, 50365, 50370, 50380, 50547. Prior authorization is needed for evaluation and actual transplant.	NA	NA
<a href="#">Laboratory Testing MP9539</a>	Not required	NA	Use applicable CPT or HCPCS codes	NA
<a href="#">Laser Spine Surgeries MP9768</a>	Not covered	NA	NA	62287
<a href="#">Laser Therapy for Nicotine Dependence MP9717</a>	Not covered	NA	NA	S8948

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<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>	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>	Not covered	NA	NA	83698
<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
<a href="#">Liposuction for the Treatment of Lymphedema or Lipedema MP9650</a>	Not required	NA	15877, 15878, 15879	NA
<a href="#">Liver Transplantation MP9614</a>	Required	00796, 47133, 47135, 47140, 47141, 47142, 47143, 47144, 47145, 47146, 47147. Prior authorization is needed for	NA	NA

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		evaluation and actual transplant.		
<a href="#">Long Term Acute Care Hospital (LTACH) MP9669</a>	Required	Prior authorization required for admission and continued stay.	NA	NA
<a href="#">Lung Transplantation MP9615</a>	Required	0494T, 0495T, 0496T, S2060, S2061, 32850, 32851, 32852, 32853, 32854, 32855, 32856. Prior authorization is needed for evaluation and actual transplant.	NA	NA
<a href="#">Magnetic Esophageal Ring for the Treatment of Gastric Reflux Disease (LINX Reflux Management System) MP9471</a>	Required	43284	NA	NA
<a href="#">Male Gynecomastia Surgery MP9581</a>	Required	19300	NA	NA
<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>	Not covered	NA	NA	E0935, E0936, E1800, E1801, E1802, E1803, E1805, E1806, E1810, E1811, E1812, E1815, E1816, E1818, E1820, E1821, E1825, E1830,

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				E1831, E1840, E1841, L4396
<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>	Not covered	NA	NA	0207T, 0563T
<a href="#">Microprocessor Controlled Knee Prostheses, With or Without Polycentric, Three-Dimensional Endoskeletal Hip Joint System MP9638</a>	Required	L5856, L5857, L5858, L5859, L5930, L5961, L5962	NA	NA
<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>	Not covered	NA	NA	27415, 29867
<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</a>	Not required	NA	Use applicable CPT or HCPCS codes	NA

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<a href="#">with pH Monitoring MP9567</a>				
<p><u>Musculoskeletal Procedures, Interventional Pain Management -</u></p> <p><u>See Carelon website:</u> <a href="https://guidelines.carelonmedicalbenefitsmanagement.com/current-musculoskeletal-guidelines/">https://guidelines.carelonmedicalbenefitsmanagement.com/current-musculoskeletal-guidelines/</a></p> <p>Click <a href="#">here</a> for additional information on Carelon prior authorization.</p> <p><u>Note:</u> 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 on an emergent basis (as part of being evaluated at the ER and prior to the patient's discharge from the hospital)</p>	<p>Required through Carelon for these services:</p> <ul style="list-style-type: none"> <li>• Epidural Injection Procedures &amp; Diagnostic Selective Nerve Root Blocks</li> <li>• Paravertebral Facet Injection/Medial Branch Nerve Block/Neurolysis (e.g., percutaneous denervation procedures)</li> <li>• Regional Sympathetic Nerve Block</li> <li>• Sacroiliac Joint Injection</li> <li>• Spinal Cord and Nerve Root Stimulators</li> </ul>	<p>27096, 62280, 62281, 62282, 62292, 62320, 62321, 62322, 62323, 62324, 62325, 62326, 62327, 63650, 63655, 63663, 63664, 63685, 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> <p><b>*Please Note - Codes 64628 and 64629</b> Between now and 11/16/24 codes 64628 and 64629 will be prior authorized through The Health Plan. This can be accomplished by completing the <a href="#">General Prior Authorization Form</a> and faxing to 608-252-0830 or emailing to <a href="mailto:ifbhealthmanagement@medic">ifbhealthmanagement@medic</a></p>	NA	NA

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are not included in the Carelton MSK program.		<a href="#">a.com</a> . On 11/17/24, Carelton will prior authorize these codes		
<p>Musculoskeletal Procedures, (Large) Joint Surgery</p> <p><u>See Carelton website:</u> <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 on Carelton 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 Carelton.</p> <p>Procedures performed on an emergent basis (as part of being evaluated at the ER and prior to the patient's</p>	<p>Required through Carelton for these services:</p> <p><u>Hip</u></p> <ul style="list-style-type: none"> <li>• Arthroplasty</li> <li>• Arthroscopy &amp; Open Procedures</li> </ul> <p><u>Knee</u></p> <ul style="list-style-type: none"> <li>• Arthroplasty</li> <li>• Arthroscopy &amp; Open Procedures</li> <li>• Autologous Chondrocyte Implantation of the Knee</li> </ul> <p><u>Shoulder</u></p> <ul style="list-style-type: none"> <li>• Arthroplasty</li> <li>• Arthroscopy &amp; Open Procedures</li> </ul>	<p>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, 29875, 29876, 29877, 29879, 29880, 29881, 29882, 29883, 29884, 29885, 29886, 29887, 29888, 29889, 29892, 29914, 29915, 29916, G0289, G0428, J7330, S2112, S2118, C9781</p>		

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discharge from the hospital) are not included in the Carelon MSK program.				
<p>Musculoskeletal Procedures, Spine</p> <p><u>See Carelon website:</u> <a href="https://guidelines.carelonmedicallbenefitsmanagement.com/current-musculoskeletal-guidelines/">https://guidelines.carelonmedicallbenefitsmanagement.com/current-musculoskeletal-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 on an emergent basis (as part of being evaluated at the ER</p>	<p>Required through Carelon for these services:</p> <p><u>Cervical</u></p> <ul style="list-style-type: none"> <li>• Decompression With/Without Fusion</li> <li>• Disc Arthroplasty</li> </ul> <p><u>Lumbar</u></p> <ul style="list-style-type: none"> <li>• Discectomy, Foraminotomy&amp; Laminotomy</li> <li>• Laminectomy</li> <li>• Fusion &amp; Treatment of Spinal Deformity</li> <li>• Disc Arthroplasty</li> <li>• Posterolateral or Intertransverse Lumbar Fusion (autograft not feasible)</li> </ul> <p>Sacroiliac Joint Fusion (Percutaneous/Minimally Invasive Techniques, Open)</p>	<p>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, 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,</p>		

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and prior to the patient's discharge from the hospital) are not included in the Carelon MSK program.	Electrical Bone Growth Stimulation, Noninvasive_- spine  Vertebroplasty/ Kyphoplasty  Bone Graft Substitutes and Bone Morphogenic Proteins  Anterior Lumbar Interbody Fusion (ALIF) or Lateral Lumbar Interbody Fusion (i.e., XLIF)	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 <b>*Please Note - Code 27280</b> Between now and 11/16/24 code 27280 will be prior authorized through The Health Plan. This can be accomplished by completing the <a href="#">General Prior Authorization Form</a> and faxing to 608-252-0830 or emailing to <a href="mailto:ifbhealthmanagement@medica.com">ifbhealthmanagement@medica.com</a> . On 11/17/24, Carelon will prior authorize these codes.		
<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>	Not required	NA	Use applicable CPT or HCPCS codes	L6026, L6715, L6880, L6882, L8701, L8702



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<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>	Not covered	NA	NA	30468
<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>	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>	Not required	NA	Use applicable CPT or HCPCS codes	NA
<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>	Not covered	NA	NA	97610
<a href="#">Noncontact Near Infrared Spectroscopy MP9780</a>	Not covered	NA	NA	If a claim is submitted, the claim will deny unless

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				coverage is mandated by state/federal laws.
<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 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.*	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, E2402, C1825, 0627T, 0628T, 0629T, 0630T, C2624, C9724, C9757, 64625, 62263, 62264, 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

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<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>	Not covered	NA	NA	E0678, E0679, E0680, E0681, E0682
<a href="#">Non-Powered or Single Use Negative Pressure Wound Therapy Systems MP9784</a>	Not covered	NA	NA	97607, 97608, A9272
<a href="#">Nutritional Counseling MP9661</a>	Not required	NA	Use applicable CPT or HCPCS codes	NA
<a href="#">Orthognathic Surgery MP9651</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,	NA	NA

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		D7948, D7949, D7950, D7995, D7996		
<a href="#">Otoplasty MP9647</a>	Required	69300	NA	NA
<a href="#">Outpatient and Inpatient Electroconvulsive Therapy (ECT) MP9570</a>	Not required	NA	90870	NA
<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>	Not covered	NA	NA	C9757
<a href="#">Pancreas-Kidney (SPK, PAK) Transplantation MP9617</a>	Required	S2065 Prior authorization is needed for evaluation and actual transplant.	NA	0585T, 0586T
<a href="#">Pancreas Transplantation (Pancreas Alone) MP9616</a>	Required	48160, 48550, 48551, 48552, 48554, 48556. Prior authorization is needed for evaluation and actual transplant.	NA	0584T, 0585T, 0586T
<a href="#">Partial Hospitalization Program (PHP) – Behavioral Health MP9555</a>	Not required	NA	Use applicable CPT or HCPCS codes	NA

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<a href="#">Pelvic Vein Embolization MP9572</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 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>	Not covered	NA	NA	Use applicable CPT or HCPCS codes
<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>	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) for Ocular Indications MP9660</a>	Not required	NA	Use applicable CPT or HCPCS codes	NA

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<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>	Not covered	NA	NA	A4541, L2006
<a href="#">Prolotherapy MP9726</a>	Not covered	NA	NA	M0076
<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>	Not covered	NA	NA	0106T, 0107T, 0108T, 0109T, 0110T, G0255
Radiology Services -  <u>See Carelon website:</u> <a href="https://guidelines.carelonmedicalbenefitsmanagement.com/current-radiology-guidelines/">https://guidelines.carelonmedicalbenefitsmanagement.com/current-radiology-guidelines/</a>	Required through Carelon for these services:  Selected applications of the following: <ul style="list-style-type: none"> <li>• Computed tomography (CT)</li> <li>• Low-dose CT</li> </ul>	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,		

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<p>Click <a href="#">here</a> for additional information on Carelon prior authorization.</p> <p><u>Note:</u> 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 patient's discharge from the hospital) are not included in the Carelon radiology program.</p>	<ul style="list-style-type: none"> <li>• Magnetic resonance imaging (MRI)</li> <li>• Functional MRI</li> <li>• Magnetic resonance spectroscopy</li> <li>• Magnetic resonance cholangiopancreatography (MRCP)</li> <li>• Positron emission tomography (PET)</li> <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>	<p>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, 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</p>		
<a href="#">Radioembolization of Hepatic Tumors MP9774</a>	Not required	NA	Use applicable CPT or HCPCS codes	NA

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<a href="#">Radiofrequency Ablation of Uterine Fibroids MP9657</a>	Not required	NA	Use applicable CPT or HCPCS codes	NA
<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>	Required	93228, 93229	NA	NA
<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>	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>	Required	Prior authorization is required for residential treatment. See medical policy for criteria.	NA	NA
<a href="#">Responsive Cortical Stimulation MP9496</a>	Not required	NA	Use applicable CPT or HCPCS codes	NA



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<a href="#">Rhinoplasty Procedure with or without Septoplasty MP9648</a>	Required	30400, 30410, 30420, 30430, 30435, 30450, 30460, 30462, 30465, 30468	NA	NA
<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>	Not covered	NA	NA	S3652
<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>	Not required	NA	0604T, 0605T, 0606T	NA
<a href="#">Scar Revision MP9649</a>	Not required	NA	Use applicable CPT or HCPCS codes	NA
<a href="#">Scrambler Pain Therapy MP9728</a>	Not covered	NA	NA	0278T
<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>	Not covered	NA	NA	95027
<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>	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>	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>	Not required	NA	Q4101, Q4102, Q4103, Q4104, Q4105, Q4106, Q4107, Q4108, Q4112, Q4114, Q4116, Q4121, Q4122, Q4130, Q4132, Q4134, Q4151, Q4182, Q4186, 15271, 15272, 15273, 15274, 15275, 15276, 15277, 15278, 15777	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, 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,

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				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, 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>	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

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<a href="#">Sphenopalatine Ganglion Block for the Treatment of Headache MP9764</a>	Not covered	NA	NA	64505
<a href="#">Stem Cell and Cellular Bone Matrix Products for Orthopedic Applications MP9758</a>	Not covered	NA	NA	0627T, 0628T, 0629T, 0630T
<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>	Not covered	NA	NA	C9781
<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 C2586 when billed with diagnosis code N400 or N401
<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>	Not covered	NA	NA	L8641

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<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>	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>	Not required	NA	Use applicable CPT or HCPCS codes	NA
<a href="#">Testing for Neutralizing Antibodies to Interferon Beta in Management of Multiple Sclerosis MP9685</a>	Not covered	NA	NA	If a claim is submitted, the claim will deny unless coverage is mandated by state/federal laws.
<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>	Not covered	NA	NA	93740

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<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>	Not covered	NA	NA	0559T, 0560T, 0561T, 0562T
<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.
<a href="#">Tongue Based Suspension Surgery MP9752</a>	Not covered	NA	NA	41512
<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>	Not required	NA	Use applicable CPT or HCPCS codes	NA
<a href="#">Transcatheter Heart Valve Replacement and Repair Procedure MP9623</a>	Not required	NA	Use applicable CPT or HCPCS codes	0569T

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Policy Name with Link	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="#">Transcranial Magnetic Stimulation MP9526</a>	Not required	NA	Use applicable CPT or HCPCS codes	NA
<a href="#">Transcutaneous Electrical Joint Stimulation Device MP9740</a>	Not covered	NA	NA	E0762
<a href="#">Transvaginal and Transurethral Radiofrequency (RF) Treatments of Stress Urinary Incontinence in Women MP9741</a>	Not covered	NA	NA	53860
<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>	Not covered	NA	NA	76498
<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>	Not required	NA	Use applicable CPT or HCPCS codes	NA

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<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>	Not covered	NA	NA	0487T
<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>	Not covered	NA	NA	92517, 92518, 92519
<a href="#">Virtual Care MP9663</a>	Not required	NA	Use applicable CPT or HCPCS codes	NA
<a href="#">Vitamin D Testing for Screening MP9686</a>	Not covered	NA	NA	82306, 82652, 0038U



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<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>	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>	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 different device requires prior authorization.	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 not require prior authorization.	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.
<a href="#">Wilderness Programs MP9723</a>	Not covered	NA	NA	T2036, T2037

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<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>	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>	Not covered	NA	NA	0598T, 0559T