



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.



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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 [Availity 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 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.

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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](#);
- 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:

Fax Number	(608) 252-0830
Email	ifbhealthmanagement@medica.com
Mailing Address	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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Abdominoplasty/Panniculectomy MP9646	Required	15830, 15839, 15847	NA	NA
Actigraphy MP9559	Not Required	NA	95803	NA
Air Ambulance, Non-Emergent MP9632	Non-emergent air ambulance transport requires prior authorization	A0140, A0430, A0431, A0435, A0436, S9960, S9961	NA	NA
Allogenic Morphogenic Protein (OsteoAMP) MP9776	Not covered	NA	NA	If a claim is submitted, the claim will deny unless coverage is mandated by state/federal laws.
Allogenic Pancreatic Islet Cell Transplantation MP9756	Not Covered	NA	NA	G0341, G0342, G0343, 0584T, 0585T, 0586T
Amino Acid-Based Elemental Formulas MP9355	Not Required	NA	B4153, B4161	NA
Annulus Fibrosis Repair Devices MP9688	Not Covered	NA	NA	C9757
Autologous Blood-Derived Products (Platelet-Rich Plasma, Autologous Conditioned Serum, Autologous Whole Blood) MP9713	Not Covered	NA	NA	0232T, 0481T, G0465, P9020, S9055

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Automated, Non-Invasive Nerve Conduction Velocity (NCV) Testing MP9689	Not covered	NA	NA	95905
Bariatric Surgery MP9319	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
Biochemical Biomarker Panel for Assessment of Hepatitis-Associated Liver Disease MP9674	Not required	NA	Use applicable CPT or HCPCS codes	0002M, 0003M, 81517, 0166U
Bioimpedance Spectroscopy (BIS) and Bioelectrical Impedance Analysis (BIA) MP9690	Not covered	NA	NA	93702, 0358T
Birth Centers (Free-Standing) MP9666	Not required	NA	Use applicable CPT or HCPCS codes	NA
Blepharoplasty, Blepharoptosis Repair, and Brow Lift MP9664	Required	15820, 15821, 15822, 15823, 67900, 67901, 67902, 67903, 67904, 67906, 67908, 67909	NA	NA

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Bone Anchored Hearing Aid MP9018	Not required	NA	69710, 69711 , 69714, 69715, 69716, 69717, 69719, 69728, 69729, 69730, L8690, L8691, L8692, L8693, L8694, S2230, V5095	NA
Bone Growth Stimulators - Electrical (Long Bones) And Ultrasound MP9076 (III-DEV.07)	Required	20974, 20975, 20979, E0747, E0748, E0749, E0760	NA	NA
Bone Marrow or Stem Cell (Peripheral or Umbilical Cord) Transplantation MP9611	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
Breast Ductal Lavage MP9691	Not covered	NA	NA	19499
Breast Implant Removal, Revision, or Reimplantation MP9580	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

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Bronchial Thermoplasty for Treatment of Asthma MP9693	Not covered	NA	NA	If a claim is submitted, the claim will deny unless coverage is mandated by state/federal laws.
Cala Trio Therapy for Essential Tremor MP9757	Not covered	NA	NA	E0734
Cardiac Event Monitors and Procedures MP9540	Not required	NA	Use applicable CPT or HCPCS codes	NA
<p><u>Cardiology -</u></p> <p><u>See Carelon website -</u> https://guidelines.carelonmedicalbenefitsmanagement.com/current-cardiology-guidelines/</p> <p>Click here for additional information on Carelon prior authorization.</p> <p>Note: Effective 10/01/2024, prior authorization for the services listed in the chart to the right will be submitted to Carelon.</p>	<p>Required through Carelon for these services:</p> <ul style="list-style-type: none"> • Cardiac Resynchronization Therapy • Diagnostic Coronary Angiography • Endovascular Revascularization • Imaging of the Heart • Implantable Cardioverter Defibrillators • Percutaneous Implantable Pacemakers • Vascular Imaging 	<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,</p>	NA	NA

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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.		93931, 93978, 93979, C1721, C1722, C1777, C1785, C1786, C1882, C1895, C1896, C1899, C2619, C2620, C2621, C7531, C7534, C7535, G0448		
Carotid Intima-Media Thickness Measurement MP9694	Not covered	NA	NA	93895
Cell Therapy for the Treatment of Cardiac Disease MP9578	Not required	NA	Use applicable CPT or HCPCS codes	0263T, 0264T, 0265T
Chemiluminescent Testing (ViziLite) for Oral Cancer Screening MP9569	Not required	NA	Use applicable CPT or HCPCS codes	NA
Chemoembolization for Hepatic Tumors MP9462	Not required	NA	Use applicable CPT or HCPCS codes	NA
Chronic Rhinitis: Cryoablation, Radiofrequency Ablation	Not required	NA	Use applicable CPT or HCPCS codes	NA

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and Laser Ablation, Office-Based MP9631				
CLEAR Institute Scoliosis Treatment Protocols MP9695	Not covered	NA	NA	E1399
Clinical Trials (Clinical Trial Participation) MP9447	Not required **Specialized lab evaluations and medical images which are part of standard of care but cannot be performed at a plan site require prior authorization through the Health Services Division.	NA	Use applicable CPT or HCPCS codes	NA
Cognitive Rehabilitation/Remediation MP9561	Not required	NA	Use applicable CPT or HCPCS codes	NA
Collagen Cross Links as Markers of Bone Turnover MP9677	Not covered	NA	NA	82523
Computerized Dynamic Posturography MP9696	Not covered	NA	NA	92548, 92549
Confocal Laser Endomicroscopy for Barrett's Esophagus MP9697	Not covered	NA	NA	43206, 43252, 0397T if billed with the following diagnosis codes: K227.10, K227.11, K227.19.
Corneal Cross-Linking (CXL) MP9470	Not required	NA	Use applicable CPT or HCPCS codes	NA

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Cranial Electrotherapy Stimulation (CES) MP9698	Not covered	NA	NA	E0732, A4596
Craniosacral Therapy MP9699	Not covered	NA	NA	97139
Cytotoxic Testing for Allergy Diagnosis MP9678	Not covered	NA	NA	86807, 86808
Day Treatment – Behavioral Health MP9557	Not required	NA	Use applicable CPT or HCPCS codes	NA
Diagnosis and Treatment of Chronic Cerebrospinal Venous Insufficiency (CCSVI) in Multiple Sclerosis MP9568	Not covered	NA	NA	If a claim is submitted, the claim will deny unless coverage is mandated by state/federal laws.
Drug Eluting Sinus Stents, Bioabsorbable MP9700	Not covered	NA	NA	S1091
Durable Medical Equipment MP9347	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, T4529, T4531, T4532, T4533, T4534, T4535, T4536, T4537, T4539, T4540, T4541, T4543, T4544, E0210, E0215, E1300, K1003, E0189,

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				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>
Elastography (Ultrasound, Acoustic Radiation Force Impulse Imaging and Shear Wave Elastography) (MP9562)	Not required	NA	76391, 76981, 76982, 76983, 91200	NA
Electric Cell-Signaling Treatment (e.g., neoGEN® System, Sanexas Intl.) (MP9701)	Not covered	NA	NA	64999, 13999
Electric Tumor Treatment Field (Optune) (MP9474)	Not covered	NA	E0766	A4555
Electrical or Electromagnetic	Not covered	NA	NA	If a claim is submitted, the claim will deny unless

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Stimulation for Healing of Chronic Wounds (MP9702)				coverage is mandated by state/federal laws.
Electromagnetic Navigation Bronchoscopy (MP9634)	Not required	NA	Use applicable CPT or HCPCS codes	NA
Endoscopic Balloon Sinuplasty Ostial Dilatation Chronic Sinusitis (MP9667)	Not required	NA	Use applicable CPT or HCPCS codes	NA
Endoscopic Procedures for the Treatment of Gastroesophageal Reflux Disease (GERD) MP9703	Not covered	NA	NA	43257
Endoscopic Radiofrequency Ablation for Barrett's Esophagus MP9628	Not required	NA	Use applicable CPT or HCPCS codes	43257
Enhanced External Counterpulsation (EECP) MP9620	Not required	NA	Use applicable CPT or HCPCS codes	NA
Epidural Lysis of Adhesions MP9704	Not covered	NA	NA	62263, 62264
Eustachian Tube Balloon Dysfunction (Acclarent AERA) MP9604	Not required	NA	69705, 69706, 69799	NA
Exhaled Breath Tests for Asthma and Other Inflammatory Pulmonary	Not required	NA	83987, 95012	NA

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Conditions: Exhaled Nitric Oxide Breath Test and Exhaled Breath Condensate pH Measurement MP9560				
Extended Hours of Home Care (Private Duty Nursing) MP9673	Required	Use applicable CPT or HCPCS codes	NA	NA
Extracorporeal Magnetic Stimulation for the Treatment of Urinary Incontinence MP9705	Not covered	NA	NA	53899
Extracorporeal Photopheresis (Photochemotherapy) MP9558	Not Required	NA	36522	NA
Extracorporeal Shock Wave Therapy (ESWT) for Musculoskeletal Indications and Soft Tissue Injuries MP9706	Not covered	NA	NA	28890, 0101T, 0102T, 0512T, 0513T
Eye-Movement Analysis without Spatial Calibration (e.g., EyeBOX® system) MP9785	Not covered	NA	NA	0615T

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Facility-Based Polysomnography, Adult (Sleep Study) MP9676	Required	95807, 95808, 95810, 95811 - Please note: these codes are applicable for 18 years and older.	NA	NA
Fecal Calprotectin Testing MP9665	Not required	NA	Use applicable CPT or HCPCS codes	NA
Female Breast Reduction Surgery – Reduction Mammoplasty MP9582	Required	19318	NA	NA
Female External Urinary Catheters for Urinary Incontinence (e.g., PureWick, PrimaFit) MP9759	Not covered	NA	NA	A6590, E2001
Food Allergy/Intolerance Testing (in vitro) MP9679	Not required	NA	Use applicable CPT or HCPCS codes	86001
Foot Care MP9656	Not required	NA	Use applicable CPT or HCPCS codes	NA
Functional Electrical Stimulation, Upper and Lower Limb MP9566	Not required	NA	Use applicable CPT or HCPCS codes	E0770, E0764
Gastric Electrical Stimulation (GES) MP9463	Not required	NA	Use applicable CPT or HCPCS codes	NA
Gastrointestinal Monitoring System (SmartPill®) MP9707	Not covered	NA	NA	91112

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Gender Affirmation Procedures MP9642	Required	<p>Prior authorization required if billed with any of the following diagnosis codes: F64.0 F64.1 F64.2 F64.8 F64.9 Z87.890</p> <p>Procedures:</p> <p>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, 11922, 11950, 11951, 11952, 11954, 14000, 14001, 14041, 15734, 15738, 15750, 15757, 15758, 15769, 15771, 15772, 15773, 15774, 15780, 15781, 15783, 15786, 15787, 15788,</p>	NA	NA

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		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		
Genetic Testing: General Approach to Genetic Testing MP9610	Not required	NA	Use applicable CPT or HCPCS codes	NA
Glaucoma Surgical Treatments (MP9467)	Not required	NA	Use applicable CPT or HCPCS codes	NA
Hair Analysis in the Clinical Setting (MP9680)	Not covered	NA	NA	P2031
Hearing Aids (MP9445)	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

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Heart\Lung Transplantation (MP9612)	Required	33930, 33933, 33935. Prior authorization is needed for evaluation and actual transplant.	NA	NA
Heart Transplantation (Adult and Pediatric) (MP9613)	Required	33940, 33944, 33945. Prior authorization is needed for evaluation and actual transplant.	NA	NA
High Intensity Focused Ultrasound (HIFU) and Magnetic Resonance Guided Focused Ultrasound (MRgFUS) (MP9708)	Not covered	NA	NA	0071T, 0072T, 0398T, 55880, C9734
Home Traction, Cervical and Lumbar MP9781	Not covered	NA	NA	If a claim is submitted, the claim will deny unless coverage is mandated by state/federal laws.
Home Use of Bilevel Positive Airway Pressure (BiPAP) for Conditions Other Than Obstructive Sleep Apnea (OSA) MP9658	Not required	NA	21120, 21121, 21122, 21123, 21199, 42145, E0470, E0471, E0472, E0485, E0486, E0601, A9279	0437T, 64582, 64583, 64584
Home Use of Continuous Positive Airway Pressure (CPAP) and Bilevel	Not required	NA	21120, 21121, 21122, 21123, 21199, 42145, E0470, E0471, E0472,	0437T, 64582, 64583, 64584

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Positive Airway Pressure (BiPAP) for Sleep Apnea MP9239			E0485, E0486, E0601, A9279	
Hospice (Inpatient and Outpatient) Services MP9299	Not required	NA	Q5001, Q5002 Q5003 Q5004 Q5005 Q5006 Q5007 Q5008 Q5010 G0182 G9473 G9474 G9475 G9476 G9477 G9478 G9479 G0337 S0255	NA
Hyperbaric Oxygen Therapy and Topical Oxygen MP9055	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
I-Factor Bone Graft MP9777	Not covered	NA	NA	If a claim is submitted, the claim will deny unless coverage is mandated by state/federal laws.
Implantable Deep Brain Stimulation (DBS) MP9331	Not required	NA	61885, 61886	NA

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Implantable Peripheral Nerve Stimulator for Treatment of Pain MP9769	Not covered	NA	NA	If a claim is submitted, the claim will deny unless coverage is mandated by state/federal laws.
Implanted Hypoglossal Nerve Stimulation for Treatment of Obstructive Sleep Apnea MP9636	Required	64568, 64582	NA	41521
Inhaled Nitric Oxide Therapy MP9654	Not required	NA	Use applicable CPT or HCPCS codes	NA
Inpatient (Hospital) Level of Care MP9671	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
Inpatient Rehabilitation (Acute Rehabilitation) MP9668	Required	Prior authorization required for admission and continued stay.	NA	NA
Intense Pulsed Light Treatment for Dry Eye Disease MP9709	Not covered	NA	NA	0507T

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Intensive Outpatient - Behavioral Health MP9556	Not required	NA	Use applicable CPT or HCPCS codes	NA
Interferential Current Stimulation MP9710	Not covered	NA	NA	S8130, S8131, E1399
Intestinal Transplantation MP9618	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
Intradiscal Electrothermal (IDET) MP9711	Not covered	NA	NA	22526, 22527
Intraoperative Neurophysiological Monitoring (IONM) MP9577	Not required	NA	Use applicable CPT or HCPCS codes	NA
Intravascular Shockwave Lithotripsy for the Treatment of Coronary Artery Disease MP9770	Not covered	NA	NA	C1761, 92972
In Vitro Chemosensitivity and Chemoresistance Assays MP9760	Not covered	NA	NA	0564T, 0083U

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Iris Prosthesis MP9715	Not covered	NA	NA	0616T, 0617T, 0618T, C1839
Irreversible Electroporation (NanoKnife System) MP9714	Not covered	NA	NA	0600T, 0601T
Kidney Transplantation MP9675	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
Laboratory Testing MP9539	Not required	NA	Use applicable CPT or HCPCS codes	NA
Laser Spine Surgeries MP9768	Not covered	NA	NA	62287
Laser Therapy for Nicotine Dependence MP9717	Not covered	NA	NA	S8948
Laser Therapy for Treatment of Pain MP9718	Not covered	NA	NA	0552T, S8948
Light Treatment and Laser Therapies for Benign Dermatologic Conditions MP9057	Not required	NA	Use applicable CPT or HCPCS codes	NA
Lipoprotein-associated Phospholipase A2 (Lp-	Not covered	NA	NA	83698

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PLA2) Immunoassay for Prediction of Risk of Coronary Heart Disease or Ischemic Stroke (PLAC Test®) MP9687				
Lipoprotein Subclass Testing for Screening, Evaluation and Monitoring of Cardiovascular Disease MP9681	Not covered	NA	NA	83700, 83701, 83704, 83772, 0052U, 0377U
Liposuction for the Treatment of Lymphedema or Lipedema MP9650	Not required	NA	15877, 15878, 15879	NA
Liver Transplantation MP9614	Required	00796, 47133, 47135, 47140, 47141, 47142, 47143, 47144, 47145, 47146, 47147. Prior authorization is needed for evaluation and actual transplant.	NA	NA
Long Term Acute Care Hospital (LTACH) MP9669	Required	Prior authorization required for admission and continued stay.	NA	NA
Lung Transplantation MP9615	Required	0494T, 0495T, 0496T, S2060, S2061, 32850, 32851, 32852, 32853, 32854, 32855, 32856. Prior	NA	NA

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		authorization is needed for evaluation and actual transplant.		
Magnetic Esophageal Ring for the Treatment of Gastric Reflux Disease (LINX Reflux Management System) MP9471	Required	43284	NA	NA
Male Gynecomastia Surgery MP9581	Required	19300	NA	NA
Mechanical Circulatory Support Devices MP9528	Not required	NA	Use applicable CPT or HCPCS codes	NA
Mechanical Stretching Devices for the Treatment of Joint Contractures of the Extremities MP9659	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, L4396
Mechanized Spinal Decompression Traction Tables for Low Back Pain MP9644	Not covered	NA	NA	E0941

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Meibomian Gland Evacuation Therapies MP9719	Not covered	NA	NA	0207T, 0563T
Microprocessor Controlled Knee Prostheses, With or Without Polycentric, Three-Dimensional Endoskeletal Hip Joint System MP9638	Required	L5856, L5857, L5858, L5859, L5930, L5961, L5962	NA	NA
mild@ Procedure (mild@ Device Kit) MP9761	Not covered	NA	NA	0275T
Minced Cartilage (Allograft) Repair for Articular Cartilage Defects MP9762	Not covered	NA	NA	27415, 29867
Motion Preserving Posterior Inter-spinous/Inter-laminar Decompression/Stabilization Devices MP9749	Not covered	NA	NA	22867, 22868, 22869, 22870, C1821
Multichannel Intraluminal Esophageal Impedance with pH Monitoring MP9567	Not required	NA	Use applicable CPT or HCPCS codes	NA
Musculoskeletal Procedures, Interventional Pain Management -	Required through Carelon for these services: <ul style="list-style-type: none"> Epidural Injection Procedures & 	27096, 62280, 62281, 62282, 62292, 62320, 62321, 62322, 62323, 62324, 62325, 62326, 62327, 63650, 63655,	NA	NA

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<p><u>See Carelon website: https://guidelines.carelonmedicalbenefitsmanagement.com/current-musculoskeletal-guidelines/</u></p> <p>Click here for additional information on Carelon prior authorization.</p> <p>Note: 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) are not included in the Carelon MSK program.</p>	<p>Diagnostic Selective Nerve Root Blocks</p> <ul style="list-style-type: none"> Paravertebral Facet Injection/Medial Branch Nerve Block/Neurolysis (e.g., percutaneous denervation procedures) Regional Sympathetic Nerve Block Sacroiliac Joint Injection Spinal Cord and Nerve Root Stimulators 	<p>63663, 63664, 63685, 63688, 64451, 64479, 64480, 64483, 64484, 64490, 64491, 64492, 64493, 64494, 64495, 64510, 64520, 64625, 64633, 64634, 64635, 64636, 94493, G0260, 0213T, 0214T, 0215T, 0216T, 0217T, 0218T</p>		

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<p>Musculoskeletal Procedures, (Large) Joint Surgery</p> <p><u>See Carelon website:</u> https://guidelines.carelonmedicalbenefitsmanagement.com/current-musculoskeletal-guidelines/</p> <p>Click here for additional information on Carelon prior authorization.</p> <p>Note: 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) are not included in the Carelon MSK program.</p>	<p>Required through Carelon for these services:</p> <p><u>Hip</u></p> <ul style="list-style-type: none"> • Arthroplasty • Arthroscopy & Open Procedures <p><u>Knee</u></p> <ul style="list-style-type: none"> • Arthroplasty • Arthroscopy & Open Procedures • Autologous Chondrocyte Implantation of the Knee <p><u>Shoulder</u></p> <ul style="list-style-type: none"> • Arthroplasty • Arthroscopy & Open Procedures 	<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, 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, 29882, 29883, 29884, 29885, 29886, 29887, 29888, 29889, 29892, 29914, 29915, 29916, 37438, G0289, G0428, J7330, S2112, S2118</p>		

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<p>Musculoskeletal Procedures, Spine</p> <p><u>See Carelon website:</u> https://guidelines.carelonmedicalbenefitsmanagement.com/current-musculoskeletal-guidelines/</p> <p>Click here 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> <p><u>Cervical</u></p> <ul style="list-style-type: none"> • Decompression With/Without Fusion • Disc Arthroplasty <p><u>Lumbar</u></p> <ul style="list-style-type: none"> • Discectomy, Foraminotomy & Laminotomy • Laminectomy • Fusion & Treatment of Spinal Deformity • Disc Arthroplasty • Posterolateral or Intertransverse Lumbar Fusion (autograft not feasible) <p>Sacroiliac Joint Fusion (Percutaneous/Minimally Invasive Techniques)</p> <p>Electrical Bone Growth Stimulation, Noninvasive, spine</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, 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, 63252, 63265, 63267, 63270, 63272, 63275, 63277, 63280, 63285, 63287, 63290, 63300, 63303, 63304, 63305, 63306, 63307, 63308, 66301, 66302, C9359, C9362,</p>		

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are not included in the Carelon MSK program.	Vertebroplasty/ Kyphoplasty Bone Graft Substitutes and Bone Morphogenic Proteins Anterior Lumbar Interbody Fusion (ALIF) or Lateral Lumbar Interbody Fusion (i.e., XLIF)	C7504, C7505, C7507, C7508, E0748, 0095T, 0098T, 0164T, 0165T, 0200T, 0201T		
Myocardial Strain Imaging (e.g., Cardiac Magnetic Resonance, Speckle Tracking Echocardiography, Tissue Doppler Echocardiography MP9771	Not covered	NA	NA	93356
Myoelectric Upper Limb Prosthetics and Orthotics MP9637	Not required	NA	Use applicable CPT or HCPCS codes	L6026, L6715, L6880, L6882, L8701, L8702
Nasal Expiratory Positive Airway Pressure (Provent) for Obstructive Sleep Apnea MP9753	Not covered	NA	NA	A7049

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Nasal Implant, Absorbable, for Treatment of Nasal Valve Collapse MP9773	Not covered	NA	NA	30468
Nebulized Intranasal Antibiotics/Antifungals for Sinusitis MP9712	Not covered	NA	NA	95199
Negative Pressure Wound Therapy with Installation System MP9720	Not covered	NA	NA	If a claim is submitted, the claim will deny unless coverage is mandated by state/federal laws.
Neurofeedback or Biofeedback for Behavioral and Substance Use Disorders MP9579	Not required	NA	Use applicable CPT or HCPCS codes	NA
Neuropsychological Testing MP9493	Not required	NA	96121, 96132, 96133	NA
Noncontact, Low-frequency Ultrasound Therapy for Healing of Chronic Wounds MP9735	Not covered	NA	NA	97610
Noncontact Near Infrared Spectroscopy MP9780	Not covered	NA	NA	If a claim is submitted, the claim will deny unless coverage is mandated by state/federal laws.
Non-Contact Normothermic Wound Therapy MP9721	Not covered	NA	NA	0859T, 0860T, 0640T

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Non-Covered Medical Procedures and Services MP9415 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. <small>*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.*</small>	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, 97605, 97606, 97608, 92499, 92700, 97039, S9101, G2170, G2171
Non-invasive Measurement of Left Ventricular End Diastolic Pressure MP9767	Not covered	NA	NA	93799
Non-pneumatic Compression Systems or	Not covered	NA	NA	E0678, E0679, E0680, E0681, E0682

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Garments (e.g., Dayspring) MP9750				
Non-Powered or Single Use Negative Pressure Wound Therapy Systems MP9784	Not covered	NA	NA	97607, 97608, A9272
Nutritional Counseling MP9661	Not required	NA	Use applicable CPT or HCPCS codes	NA
Orthognathic Surgery MP9651	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, 21685, D7940, D7941, D7943, D7944, D7945, D7946, D7947, D7948, D7949, D7950, D7995, D7996	NA	NA
Otoplasty MP9647	Required	69300	NA	NA
Outdoor Behavioral Therapy MP9723	Not covered	NA	NA	T2036, T2037

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Outpatient and Inpatient Electroconvulsive Therapy (ECT) MP9570	Not required	NA	90870	NA
Outpatient Enteral Therapy MP9069	Required	B4102, B4103, B4104, B4149, B4150, B4152, B4153, B4154, B4155, B4157, B4158, B4159, B4160, B4161, B4162	NA	B4105
Palatal Implants for Obstructive Sleep Apnea MP9754	Not covered	NA	NA	C9757
Pancreas-Kidney (SPK, PAK) Transplantation MP9617	Required	S2065 Prior authorization is needed for evaluation and actual transplant.	NA	0585T, 0586T
Pancreas Transplantation (Pancreas Alone) MP9616	Required	48160, 48550, 48551, 48552, 48554, 48556. Prior authorization is needed for evaluation and actual transplant.	NA	0584T, 0585T, 0586T
Partial Hospitalization Program (PHP) – Behavioral Health MP9555	Not required	NA	Use applicable CPT or HCPCS codes	NA
Pelvic Vein Embolization MP9572	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.
Percutaneous Disc Decompression Procedures (Percutaneous Discectomies, Nucleoplasty) MP9734	Not covered	NA	NA	62287, S2348
Percutaneous Neuromodulation Therapy for the Treatment of Pain MP9724	Not covered	NA	NA	Use applicable CPT or HCPCS codes
Percutaneous Tibial Nerve Stimulation MP9563	Not required	NA	Use applicable CPT or HCPCS codes	NA
Percutaneous Ultrasonic Ablation of Soft Tissue MP9725	Not covered	NA	NA	If a claim is submitted, the claim will deny unless coverage is mandated by state/federal laws.
Photodynamic Therapy with Visudyne®(verteprofin) for Ocular Indications MP9660	Not required	NA	Use applicable CPT or HCPCS codes	NA
Phrenic Nerve Stimulation for Central Sleep Apnea MP9755	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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Powered Robotic Lower-Limb Exoskeleton Devices MP9645	Not covered	NA	NA	A4541, L2006
Prolotherapy MP9726	Not covered	NA	NA	M0076
Quantitative Electroencephalogram (qEEG) and Referenced Electroencephalogram (rEEG) MP9622	Not required	NA	Use applicable CPT or HCPCS codes	NA
Quantitative Sensory Tests MP9727	Not covered	NA	NA	0106T, 0107T, 0108T, 0109T, 0110T, G0255
<p>Radiology Services -</p> <p><u>See Carelon website:</u> https://guidelines.carelonmedicalbenefitsmanagement.com/current-radiology-guidelines/</p> <p>Click here for additional information on Carelon prior authorization.</p>	<p>Required through Carelon for these services:</p> <p>Selected applications of the following:</p> <ul style="list-style-type: none"> • Computed tomography (CT) • Low-dose CT • Magnetic resonance imaging (MRI) • Functional MRI • Magnetic resonance spectroscopy 	<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,</p>		

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<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"> • Magnetic resonance cholangiopancreatography (MRCP) • Positron emission tomography (PET) • CT or MR arthrography • Low-field MRI • MR-guided Procedures • Nuclear Medicine Imaging • Oncologic Imaging • SPECT Imaging • Vascular Imaging 	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		
Radioembolization of Hepatic Tumors MP9774	Not required	NA	Use applicable CPT or HCPCS codes	NA
Radiofrequency Ablation of Uterine Fibroids MP9657	Not required	NA	Use applicable CPT or HCPCS codes	NA

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Radiofrequency Volumetric Tissue Reduction for Obstructive Sleep Apnea MP9751	Not covered	NA	NA	41530
Real-Time Mobile Cardiac Outpatient Telemetry MP9621	Required	93228, 93229	NA	NA
Remote Patient Monitoring (RPM) and Remote Therapeutic Monitoring (RTM) MP9716	Not required	NA	99091, 99453, 99454, 99457, 99458, 99474, G0322	98975, 98976, 98977, 98978, 98980, 98981
Repairs/Replacement of Durable Medical Equipment/Supplies MP9106	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
Residential Treatment – Behavioral Health MP9554	Required	Prior authorization is required for residential treatment. See medical policy for criteria.	NA	NA
Responsive Cortical Stimulation MP9496	Not required	NA	Use applicable CPT or HCPCS codes	NA
Rhinoplasty Procedure with or without Septoplasty MP9648	Required	30400, 30410, 30420, 30430, 30435, 30450,	NA	NA

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		30460, 30462, 30465, 30468		
Sacral Nerve Stimulation MP9624	Not required	NA	Use applicable CPT or HCPCS codes	NA
Sacroiliac (SI) Joint Fusion, Open MP9643	Required	0809T, 27279, 27280, 0775T	NA	NA
Salivary Estriol Test for Preterm Labor MP9682	Not covered	NA	NA	S3652
Salivary Hormone Tests MP9683	Not covered	NA	NA	S3650
Scanning Laser Technologies for Retina and Optic Nerve Imaging MP9629	Not required	NA	0604T, 0605T, 0606T	NA
Scar Revision MP9649	Not required	NA	Use applicable CPT or HCPCS codes	NA
Scrambler Pain Therapy MP9728	Not covered	NA	NA	0278T

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Sensory and Auditory Integration Therapies MP9729	Not covered	NA	NA	97533
Serial Dilution Endpoint Titration for Diagnosis and Treatment of Airborne Allergy MP9684	Not covered	NA	NA	95027
Services Related to Dental Care MP9271	Not required	NA	Use applicable CPT or HCPCS codes	NA
Single Photon Emission Computed Tomography (SPECT) for Attention Deficit Hyperactivity Disorder (ADHD) MP9633	Not covered	NA	NA	If a claim is submitted, the claim will deny unless coverage is mandated by state/federal laws.
Skilled Nursing Facility MP9670	Required	Prior authorization required for admission and continued stay.	NA	NA
Skin and Soft Tissue Engineered Substitutes for Wound and Surgical Care MP9655	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,	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,

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			15276, 15277, 15278, 15777	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, C1762, C1763, C1781, C9250, C9354, C9355, C9356, C9358, C9360, C9361, C9364, C9399, A4649
Sleep Studies for the Initial Diagnosis of Obstructive Sleep Apnea (OSA) (MP9673)	Required Prior authorization is required for in lab sleep studies for members older than 18 years of age. Prior Authorization is not required for Home-based studies OR for facility-based	95807, 95808, 95810, 95811	NA	NA

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	studies for members less than 18 years of age.			
Sphenopalatine Ganglion Block for the Treatment of Headache MP9764	Not covered	NA	NA	64505
Stem Cell and Cellular Bone Matrix Products for Orthopedic Applications MP9758	Not covered	NA	NA	0627T, 0628T, 0629T, 0630T
Stem Cell Therapy for Peripheral Artery Disease MP9730	Not covered	NA	NA	0263T, 0264T, 0265T
Subacromial Tissue Spacer for Treatment of Rotator Cuff MP9731	Not covered	NA	NA	C9781
Surgical and Minimally Invasive Treatments for Benign Prostatic Hypertrophy/Hyperplasia (BPH) MP9361	Not required	NA	Use applicable CPT or HCPCS codes	0421T, 55880, 0619T C2586 when billed with diagnosis code N400 or N401
Surgical Interruption of Pelvic Nerve Pathways for Treatment of Pelvic Pain MP9732	Not covered	NA	NA	58578

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Synthetic Cartilage Implants for First Metatarsal Phalangeal Joint MP9778	Not covered	NA	NA	L8641
Synthetic Ceramic-Based and Bioactive Glass Bone MP9787	Not covered	NA	NA	A2002, C9359, C9362, 0707T
Technology Assisted Surgical Techniques (Robotic Surgery) MP9546	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
Telehealth MP9662	Not required	NA	Use applicable CPT or HCPCS codes	NA
Testing for Neutralizing Antibodies to Interferon Beta in Management of Multiple Sclerosis MP9685	Not covered	NA	NA	If a claim is submitted, the claim will deny unless coverage is mandated by state/federal laws.
Therapeutic Apheresis (TA) – Plasmapheresis, Plasma Exchange MP9627	Not required	NA	Use applicable CPT or HCPCS codes	NA

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Thermography MP9733	Not covered	NA	NA	93740
Thoracic Electrical Bioimpedance (TEB) for Cardiac Output Measurement MP9737	Not covered	NA	NA	97301
Three Dimensional (3-D) Printed Anatomic Modeling for Surgical Planning MP9738	Not covered	NA	NA	0559T, 0560T, 0561T, 0562T
Tidal Knee Lavage for Osteoarthritis MP9739	Not covered	NA	NA	If a claim is submitted, the claim will deny unless coverage is mandated by state/federal laws.
Tongue Based Suspension Surgery MP9752	Not covered	NA	NA	41512
Total Ankle Replacement MP9363	Not required	NA	Use applicable CPT or HCPCS codes	NA
Transcatheter Closure of Cardiac Defects MP9625	Not required	NA	Use applicable CPT or HCPCS codes	NA

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Transcatheter Heart Valve Replacement and Repair Procedure MP9623	Not required	NA	Use applicable CPT or HCPCS codes	0569T
Transcranial Magnetic Stimulation MP9526	Not required	NA	Use applicable CPT or HCPCS codes	NA
Transcutaneous Electrical Joint Stimulation Device MP9740	Not covered	NA	NA	E0762
Transvaginal and Transurethral Radiofrequency (RF) Treatments of Stress Urinary Incontinence in Women MP9741	Not covered	NA	NA	53860
Trigger Point Dry Needling MP9672	Not covered	NA	NA	20560, 20561
Upright Magnetic Resonance Imaging (MRI) (Standing/Seated/Weight Bearing/Positional MRI) MP9742	Not covered	NA	NA	76498
Urine Drug Testing (UDT) Presumptive and Definitive MP9460	Not required	NA	Use applicable CPT or HCPCS codes	NA

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Urethral Bulking Agents for Urinary Incontinence MP9475	Not required	NA	Use applicable CPT or HCPCS codes	NA
Uvulopalatopharyngoplasty (UPPP or U3P) for Obstructive Sleep Apnea/Hypopnea Syndrome MP9775	Required	S2080	NA	NA
Vaginal Tactile Imaging MP9743	Not covered	NA	NA	0487T
Vein Disease Treatment MP9241	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
Vestibular Evoked Myogenic Potentials (VEMP) MP9744	Not covered	NA	NA	92517, 92518, 92519
Virtual Care MP9663	Not required	NA	Use applicable CPT or HCPCS codes	NA

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Vitamin D Testing for Screening MP9686	Not covered	NA	NA	82306, 82652, 0038U
VivAer Airway Remodeling for Airway Obstruction MP9745	Not covered	NA	NA	If a claim is submitted, the claim will deny unless coverage is mandated by state/federal laws.
Volara Oscillation and Lung Expansion System MP9746	Not covered	NA	NA	If a claim is submitted, the claim will deny unless coverage is mandated by state/federal laws.
Wheelchairs, Scooters and Accessories MP9782 (III-DEV.25)	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.

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Wireless Capsule Endoscopy (CE) and Capsule Technology to Verify Patency Prior to Capsule Endoscopy MP9626	Not required	NA	96110, 0651T	NA
Wireless Pulmonary Artery Pressure Monitoring Systems for Monitoring Heart Failure (CardioMEMS) MP9748	Not covered	NA	NA	33289, 93264
Wound Imaging and Measuring Systems for Managing Chronic Wounds (e.g., Fluorescent Wound Imaging; Camera Wound Imaging) MP9783	Not covered	NA	NA	0598T, 0559T