



**BlueCross BlueShield
of Illinois**

**Illinois Medicaid Prior Authorization
Procedure Code List, Effective 1/1/2021
(Updated 10/1/2021)**

This list includes Current Procedural Terminology (CPT®) and/or Healthcare Common Procedure Coding System (HCPCS) codes related to services/categories for which benefit preauthorization may be required. This list is not exhaustive. The presence of codes on this list does not necessarily indicate coverage under the member benefits contract. Always check eligibility and benefits first, prior to rendering services. Member contracts differ in their benefits. Consult the member benefit booklet, or contact a customer service representative to determine coverage for a specific medical service or supply.

Note: Green highlighted codes are managed by eviCore healthcare (eviCore). Orange highlighted codes are managed by eviCore for Blue Cross Community Health PlansSM (BCCHPSM) members and by Prime Therapeutics for Blue Cross Community MMAI (Medicare-Medicaid)SM members.

Utilization Management Process

| CPT and HCPCS Codes That May Require Prior Authorization | Description of Procedure Code | Medical Records Request Information Required |
|--|-------------------------------|---|
| 11920 | CORRECT SKIN COLOR 6.0 CM/< | Pre-operative evaluation, history and physical including functional impairment, and operative report. |
| 01990 | SUPPORT FOR ORGAN DONOR | Recent history and physical, plan of care, and documentation of medical necessity. |
| 11921 | CORRECT SKN COLOR 6.1-20.0CM | Pre-operative evaluation, history and physical including functional impairment, and operative report. |
| 11922 | CORRECT SKIN COLOR EA 20.0CM | Pre-operative evaluation, history and physical including functional impairment, and operative report. |
| 11950 | TX CONTOUR DEFECTS 1 CC/< | Pre-operative evaluation, history and physical including functional impairment, and operative report. |
| 11951 | TX CONTOUR DEFECTS 1.1-5.0CC | Pre-operative evaluation, history and physical including functional impairment, and operative report. |
| 11952 | TX CONTOUR DEFECTS 5.1-10CC | Pre-operative evaluation, history and physical including functional impairment, and operative report. |
| 11954 | TX CONTOUR DEFECTS >10.0 CC | Pre-operative evaluation, history and physical including functional impairment, and operative report. |

| CPT and HCPCS Codes That May Require Prior Authorization | Description of Procedure Code | Medical Records Request Information Required |
|--|-------------------------------|---|
| 11960 | INSERT TISSUE EXPANDER(S) | Pre-operative evaluation, history and physical including functional impairment, and operative report. |
| 15002 | WOUND PREP TRK/ARM/LEG | Pre-operative evaluation, history and physical including functional impairment, and operative report. |
| 15003 | WOUND PREP ADDL 100 CM | Pre-operative evaluation, history and physical including functional impairment, and operative report. |
| 15004 | WOUND PREP F/N/HF/G | Pre-operative evaluation, history and physical including functional impairment, and operative report. |
| 15005 | WND PREP F/N/HF/G ADDL CM | Pre-operative evaluation, history and physical including functional impairment, and operative report. |
| 15275 | SKIN SUB GRAFT FACE/NK/HF/G | Letter of medical necessity, including condition being treated. |
| 15780 | DERMABRASION TOTAL FACE | Pre-operative evaluation, history and physical including functional impairment, and operative report. |
| 15781 | DERMABRASION SEGMENTAL FACE | Pre-operative evaluation, history and physical including functional impairment, and operative report. |
| 15782 | DERMABRASION OTHER THAN FACE | Pre-operative evaluation, history and physical including functional impairment, and operative report. |
| 15783 | DERMABRASION SUPRFL ANY SITE | Pre-operative evaluation, history and physical including functional impairment, and operative report. |
| 15786 | ABRASION LESION SINGLE | Pre-operative evaluation, history and physical including functional impairment, and operative report. |
| 15787 | ABRASION LESIONS ADD-ON | Pre-operative evaluation, history and physical including functional impairment, and operative report. |
| 15788 | CHEMICAL PEEL FACE EPIDERM | Pre-operative evaluation, history and physical including functional impairment, and operative report. |
| 15789 | CHEMICAL PEEL FACE DERMAL | Pre-operative evaluation, history and physical including functional impairment, and operative report. |
| 15792 | CHEMICAL PEEL NONFACIAL | Pre-operative evaluation, history and physical including functional impairment, and operative report. |

| CPT and HCPCS Codes That May Require Prior Authorization | Description of Procedure Code | Medical Records Request Information Required |
|--|-------------------------------|--|
| 15793 | CHEMICAL PEEL NONFACIAL | Pre-operative evaluation, history and physical including functional impairment, and operative report. |
| 15819 | PLASTIC SURGERY NECK | Pre-operative evaluation, history and physical including functional impairment, and operative report. |
| 15820 | REVISION OF LOWER EYELID | Pre-operative Evaluation, history and physical including functional impairment, operative report and photographs of the affected eyes. |
| 15821 | REVISION OF LOWER EYELID | Pre-operative Evaluation, history and physical including functional impairment, operative report and photographs of the affected eyes. |
| 15822 | REVISION OF UPPER EYELID | Pre-operative Evaluation, history and physical including functional impairment, operative report and photographs of the affected eyes. |
| 15823 | REVISION OF UPPER EYELID | Pre-operative Evaluation, history and physical including functional impairment, operative report and photographs of the affected eyes. |
| 15824 | REMOVAL OF FOREHEAD WRINKLES | Pre-operative evaluation, history and physical including functional impairment, and operative report. |
| 15825 | REMOVAL OF NECK WRINKLES | Pre-operative evaluation, history and physical including functional impairment, and operative report. |
| 15826 | REMOVAL OF BROW WRINKLES | Pre-operative evaluation, history and physical including functional impairment, and operative report. |
| 15828 | REMOVAL OF FACE WRINKLES | Pre-operative evaluation, history and physical including functional impairment, and operative report. |
| 15829 | REMOVAL OF SKIN WRINKLES | Pre-operative evaluation, history and physical including functional impairment, and operative report. |
| 15830 | EXC SKIN ABD | Pre-operative evaluation, history and physical including functional impairment, and operative report. |
| 15832 | EXCISE EXCESSIVE SKIN THIGH | Pre-operative evaluation, history and physical including functional impairment, and operative report. |
| 15833 | EXCISE EXCESSIVE SKIN LEG | Pre-operative evaluation, history and physical including functional impairment, and operative report. |

| CPT and HCPCS Codes That May Require Prior Authorization | Description of Procedure Code | Medical Records Request Information Required |
|--|-------------------------------|---|
| 15834 | EXCISE EXCESSIVE SKIN HIP | Pre-operative evaluation, history and physical including functional impairment, and operative report. |
| 15835 | EXCISE EXCESSIVE SKIN BUTTCK | Pre-operative evaluation, history and physical including functional impairment, and operative report. |
| 15836 | EXCISE EXCESSIVE SKIN ARM | Pre-operative evaluation, history and physical including functional impairment, and operative report. |
| 15837 | EXCISE EXCESS SKIN ARM/HAND | Pre-operative evaluation, history and physical including functional impairment, and operative report. |
| 15838 | EXCISE EXCESS SKIN FAT PAD | Pre-operative evaluation, history and physical including functional impairment, and operative report. |
| 15839 | EXCISE EXCESS SKIN & TISSUE | Pre-operative evaluation, history and physical including functional impairment, and operative report. |
| 15847 | EXC SKIN ABD ADD-ON | Pre-operative evaluation, history and physical including functional impairment, and operative report. |
| 15876 | SUCTION LIPECTOMY HEAD&NECK | Pre-operative evaluation, history and physical including functional impairment, and operative report. |
| 15877 | SUCTION LIPECTOMY TRUNK | Pre-operative evaluation, history and physical including functional impairment, and operative report. |
| 15878 | SUCTION LIPECTOMY UPR EXTREM | Pre-operative evaluation, history and physical including functional impairment, and operative report. |
| 15879 | SUCTION LIPECTOMY LWR EXTREM | Pre-operative evaluation, history and physical including functional impairment, and operative report. |
| 17107 | DESTRUCTION OF SKIN LESIONS | Letter of medical necessity, including condition being treated. |
| 17340 | CRYOTHERAPY OF SKIN | Pre-operative evaluation, history and physical including functional impairment, and operative report. |
| 17360 | SKIN PEEL THERAPY | Pre-operative evaluation, history and physical including functional impairment, and operative report. |
| 17380 | HAIR REMOVAL BY ELECTROLYSIS | Pre-operative evaluation, history and physical including functional impairment, and operative report. |

| CPT and HCPCS Codes That May Require Prior Authorization | Description of Procedure Code | Medical Records Request Information Required |
|--|-------------------------------|---|
| 19020 | INCISION OF BREAST LESION | Pre-operative evaluation, history and physical including functional impairment, and operative report. |
| 19120 | REMOVAL OF BREAST LESION | Pre-operative evaluation, history and physical including functional impairment, and operative report. |
| 19301 | PARTIAL MASTECTOMY | Pre-operative evaluation, history and physical including functional impairment, and operative report. |
| 19303 | MAST SIMPLE COMPLETE | Pre-operative evaluation, history and physical including functional impairment, and operative report. |
| 19304 | MAST SUBQ | Pre-operative office evaluation, pathology report, operative report, age, medication records, length of time condition present. |
| 19316 | SUSPENSION OF BREAST | Pre-operative evaluation, history and physical including functional impairment and operative report. |
| 19318 | REDUCTION OF LARGE BREAST | Pre-operative evaluation, height/ weight, previous conservative treatment tried, pathology report, operative report, number of grams of tissue removed. |
| 19324 | ENLARGE BREAST | Pre-operative evaluation, history and physical including functional impairment, and operative report. |
| 19325 | ENLARGE BREAST WITH IMPLANT | Pre-operative evaluation, history and physical including functional impairment, and operative report. |
| 19328 | REMOVAL OF BREAST IMPLANT | Pre-operative evaluation, history and physical including functional impairment, and operative report. |
| 19330 | REMOVAL OF IMPLANT MATERIAL | Pre-operative evaluation, history and physical including functional impairment, and operative report. |
| 19340 | IMMEDIATE BREAST PROSTHESIS | Pre-operative evaluation, history and physical including functional impairment, and operative report. |
| 19342 | DELAYED BREAST PROSTHESIS | Pre-operative evaluation, history and physical including functional impairment, and operative report. |
| 19350 | BREAST RECONSTRUCTION | Pre-operative evaluation, history and physical including functional impairment, and operative report. |
| 20552 | INJ TRIGGER POINT 1/2 MUSCL | Pre-operative evaluation, history and physical including functional impairment, and operative report. |

| CPT and HCPCS Codes That May Require Prior Authorization | Description of Procedure Code | Medical Records Request Information Required |
|--|-------------------------------|--|
| 20553 | INJECT TRIGGER POINTS 3/> | Pre-operative evaluation, history and physical including functional impairment, and operative report. |
| 20930 | SP BONE ALGRFT MORSEL ADD-ON | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 20931 | SP BONE ALGRFT STRUCT ADD-ON | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 20936 | SP BONE AGRFT LOCAL ADD-ON | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 20937 | SP BONE AGRFT MORSEL ADD-ON | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 20938 | SP BONE AGRFT STRUCT ADD-ON | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 20974 | ELECTRICAL BONE STIMULATION | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 20975 | ELECTRICAL BONE STIMULATION | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 21083 | PREPARE FACE/ORAL PROSTHESIS | Pre-operative evaluation, history and physical including functional impairment, and operative report. |
| 21085 | PREPARE FACE/ORAL PROSTHESIS | Fax BA to Dental Review. Submit chart notes including type of appliance, history of re- occurring TMJ, and copy of diagnostic sleep studies. |
| 21120 | RECONSTRUCTION OF CHIN | Fax BA to Dental Review. Submit chart notes including type of appliance, history of re- occurring TMJ, and copy of diagnostic sleep studies. |
| 21121 | RECONSTRUCTION OF CHIN | Fax BA to Dental Review. Submit chart notes including type of appliance, history of re- occurring TMJ, and copy of diagnostic sleep studies. |
| 21122 | RECONSTRUCTION OF CHIN | Fax BA to Dental Review. Submit chart notes including type of appliance, history of re- occurring TMJ, and copy of diagnostic sleep studies. |
| 21123 | RECONSTRUCTION OF CHIN | Fax BA to Dental Review. Submit chart notes including type of appliance, history of re- occurring TMJ, and copy of diagnostic sleep studies. |
| 21125 | AUGMENTATION LOWER JAW BONE | Fax BA to Dental Review. Submit chart notes including type of appliance, history of re- occurring TMJ, and copy of diagnostic sleep studies. |
| 21127 | AUGMENTATION LOWER JAW BONE | Fax BA to Dental Review. Submit chart notes including type of appliance, history of re- occurring TMJ, and copy of diagnostic sleep studies. |
| 21138 | REDUCTION OF FOREHEAD | History and physical, documentation of medical necessity and previous stages of reconstruction if done. |

| CPT and HCPCS Codes That May Require Prior Authorization | Description of Procedure Code | Medical Records Request Information Required |
|--|-------------------------------|--|
| 21141 | LEFORT I-1 PIECE W/O GRAFT | Fax BA to Dental Review. Submit chart notes including type of appliance, history of re- occurring TMJ, and copy of diagnostic sleep studies. |
| 21142 | LEFORT I-2 PIECE W/O GRAFT | Fax BA to Dental Review. Submit chart notes including type of appliance, history of re- occurring TMJ, and copy of diagnostic sleep studies. |
| 21143 | LEFORT I-3/> PIECE W/O GRAFT | Fax BA to Dental Review. Submit chart notes including type of appliance, history of re- occurring TMJ, and copy of diagnostic sleep studies. |
| 21145 | LEFORT I-1 PIECE W/ GRAFT | Fax BA to Dental Review. Submit chart notes including type of appliance, history of re- occurring TMJ, and copy of diagnostic sleep studies. |
| 21146 | LEFORT I-2 PIECE W/ GRAFT | Fax BA to Dental Review. Submit chart notes including type of appliance, history of re- occurring TMJ, and copy of diagnostic sleep studies. |
| 21147 | LEFORT I-3/> PIECE W/ GRAFT | Fax BA to Dental Review. Submit chart notes including type of appliance, history of re- occurring TMJ, and copy of diagnostic sleep studies. |
| 21150 | LEFORT II ANTERIOR INTRUSION | Fax BA to Dental Review. Submit chart notes including type of appliance, history of re- occurring TMJ, and copy of diagnostic sleep studies. |
| 21151 | LEFORT II W/BONE GRAFTS | Fax BA to Dental Review. Submit chart notes including type of appliance, history of re- occurring TMJ, and copy of diagnostic sleep studies. |
| 21154 | LEFORT III W/O LEFORT I | Fax BA to Dental Review. Submit chart notes including type of appliance, history of re- occurring TMJ, and copy of diagnostic sleep studies. |
| 21155 | LEFORT III W/ LEFORT I | Fax BA to Dental Review. Submit chart notes including type of appliance, history of re- occurring TMJ, and copy of diagnostic sleep studies. |
| 21159 | LEFORT III W/FHDW/O LEFORT I | Fax BA to Dental Review. Submit chart notes including type of appliance, history of re- occurring TMJ, and copy of diagnostic sleep studies. |
| 21160 | LEFORT III W/FHD W/ LEFORT I | Fax BA to Dental Review. Submit chart notes including type of appliance, history of re- occurring TMJ, and copy of diagnostic sleep studies. |
| 21188 | RECONSTRUCTION OF MIDFACE | Pre-operative evaluation, history and physical including functional impairment, and operative report. |
| 21193 | RECONST LWR JAW W/O GRAFT | Fax BA to Dental Review. Submit chart notes including type of appliance, history of re- occurring TMJ, and copy of diagnostic sleep studies. |

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|--|-------------------------------|--|
| 21194 | RECONST LWR JAW W/GRAFT | Fax BA to Dental Review. Submit chart notes including type of appliance, history of re- occurring TMJ, and copy of diagnostic sleep studies. |
| 21195 | RECONST LWR JAW W/O FIXATION | Fax BA to Dental Review. Submit chart notes including type of appliance, history of re- occurring TMJ, and copy of diagnostic sleep studies. |
| 21196 | RECONST LWR JAW W/FIXATION | Fax BA to Dental Review. Submit chart notes including type of appliance, history of re- occurring TMJ, and copy of diagnostic sleep studies. |
| 21198 | RECONSTR LWR JAW SEGMENT | Fax BA to Dental Review. Submit chart notes including type of appliance, history of re- occurring TMJ, and copy of diagnostic sleep studies. |
| 21199 | RECONSTR LWR JAW W/ADVANCE | Fax BA to Dental Review. Submit chart notes including type of appliance, history of re- occurring TMJ, and copy of diagnostic sleep studies. |
| 21206 | RECONSTRUCT UPPER JAW BONE | Fax BA to Dental Review. Submit chart notes including type of appliance, history of re- occurring TMJ, and copy of diagnostic sleep studies. |
| 21208 | AUGMENTATION OF FACIAL BONES | Fax BA to Dental Review. Submit chart notes including type of appliance, history of re- occurring TMJ, and copy of diagnostic sleep studies. |
| 21209 | REDUCTION OF FACIAL BONES | Fax BA to Dental Review. Submit chart notes including type of appliance, history of re- occurring TMJ, and copy of diagnostic sleep studies. |
| 21210 | FACE BONE GRAFT | Submit history and physical, documentation of medical necessity including operative report. |
| 21215 | LOWER JAW BONE GRAFT | Submit history and physical, documentation of medical necessity including operative report. |
| 21230 | RIB CARTILAGE GRAFT | Submit history and physical, documentation of medical necessity including operative report. |
| 21244 | RECONSTRUCTION OF LOWER JAW | Submit history and physical, documentation of medical necessity including operative report. |
| 21245 | RECONSTRUCTION OF JAW | Submit history and physical, documentation of medical necessity including operative report. |
| 21246 | RECONSTRUCTION OF JAW | Submit history and physical, documentation of medical necessity including operative report. |
| 21270 | AUGMENTATION CHEEK BONE | Submit history and physical, documentation of medical necessity including operative report. |
| 21685 | HYOID MYOTOMY & SUSPENSION | Submit history and physical, documentation of medical necessity including operative report. |
| 21740 | RECONSTRUCTION OF STERNUM | Submit history and physical, documentation of medical necessity including operative report. |
| 22505 | MANIPULATION OF SPINE | Submit history and physical, documentation of medical necessity including operative report. |

| CPT and HCPCS Codes That May Require Prior Authorization | Description of Procedure Code | Medical Records Request Information Required |
|--|-------------------------------|--|
| 22510 | PERQ CERVICOTHORACIC INJECT | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 22511 | PERQ LUMBOSACRAL INJECTION | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 22512 | VERTEBROPLASTY ADDL INJECT | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 22513 | PERQ VERTEBRAL AUGMENTATION | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 22514 | PERQ VERTEBRAL AUGMENTATION | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 22515 | PERQ VERTEBRAL AUGMENTATION | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 22526 | IDET SINGLE LEVEL | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 22527 | IDET 1 OR MORE LEVELS | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 22533 | LAT LUMBAR SPINE FUSION | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 22534 | LAT THOR/LUMB ADDL SEG | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 22551 | NECK SPINE FUSE&REMOV BEL C2 | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 22552 | ADDL NECK SPINE FUSION | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 22554 | NECK SPINE FUSION | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 22558 | LUMBAR SPINE FUSION | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 22585 | ADDITIONAL SPINAL FUSION | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 22595 | NECK SPINAL FUSION | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 22600 | NECK SPINE FUSION | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 22612 | LUMBAR SPINE FUSION | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 22614 | SPINE FUSION EXTRA SEGMENT | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 22630 | LUMBAR SPINE FUSION | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 22632 | SPINE FUSION EXTRA SEGMENT | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 22633 | LUMBAR SPINE FUSION COMBINED | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |

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|--|-------------------------------|---|
| 22634 | SPINE FUSION EXTRA SEGMENT | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 22800 | POST FUSION </6 VERT SEG | Submit history and physical, operative report, documentation of conservative measures. |
| 22802 | POST FUSION 7-12 VERT SEG | Submit history and physical, operative report, documentation of conservative measures. |
| 22804 | POST FUSION 13/> VERT SEG | Submit history and physical, operative report, documentation of conservative measures. |
| 22808 | ANT FUSION 2-3 VERT SEG | Submit history and physical, operative report, documentation of conservative measures. |
| 22810 | ANT FUSION 4-7 VERT SEG | Submit history and physical, operative report, documentation of conservative measures. |
| 22812 | ANT FUSION 8/> VERT SEG | Submit history and physical, operative report, documentation of conservative measures. |
| 22840 | INSERT SPINE FIXATION DEVICE | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 22841 | INSERT SPINE FIXATION DEVICE | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 22842 | INSERT SPINE FIXATION DEVICE | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 22843 | INSERT SPINE FIXATION DEVICE | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 22844 | INSERT SPINE FIXATION DEVICE | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 22845 | INSERT SPINE FIXATION DEVICE | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 22846 | INSERT SPINE FIXATION DEVICE | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 22847 | INSERT SPINE FIXATION DEVICE | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 22848 | INSERT PELV FIXATION DEVICE | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 22853 | INSJ BIOMECHANICAL DEVICE | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 22854 | INSJ BIOMECHANICAL DEVICE | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 22856 | CERV ARTIFIC DISKECTOMY | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 22857 | LUMBAR ARTIF DISKECTOMY | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 22858 | SECOND LEVEL CER DISKECTOMY | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 22859 | INSJ BIOMECHANICAL DEVICE | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |

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|--|-------------------------------|---|
| 22861 | REVISE CERV ARTIFIC DISC | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 22862 | REVISE LUMBAR ARTIF DISC | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 22864 | REMOVE CERV ARTIF DISC | Recent history and physical, plan of care, and documentation of medical necessity. |
| 22867 | INSJ STABLJ DEV W/DCMPRN | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 22868 | INSJ STABLJ DEV W/DCMPRN | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 22869 | INSJ STABLJ DEV W/O DCMPRN | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 22870 | INSJ STABLJ DEV W/O DCMPRN | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 22999 | ABDOMEN SURGERY PROCEDURE | Recent history and physical, plan of care, and documentation of medical necessity. |
| 23000 | REMOVAL OF CALCIUM DEPOSITS | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 23020 | RELEASE SHOULDER JOINT | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 23120 | PARTIAL REMOVAL COLLAR BONE | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 23130 | REMOVE SHOULDER BONE PART | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 23410 | REPAIR ROTATOR CUFF ACUTE | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 23412 | REPAIR ROTATOR CUFF CHRONIC | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 23415 | RELEASE OF SHOULDER LIGAMENT | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 23420 | REPAIR OF SHOULDER | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 23430 | REPAIR BICEPS TENDON | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 23440 | REMOVE/TRANSPLANT TENDON | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 23450 | REPAIR SHOULDER CAPSULE | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 23455 | REPAIR SHOULDER CAPSULE | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 23460 | REPAIR SHOULDER CAPSULE | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 23462 | REPAIR SHOULDER CAPSULE | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |

| CPT and HCPCS Codes That May Require Prior Authorization | Description of Procedure Code | Medical Records Request Information Required |
|--|-------------------------------|---|
| 23465 | REPAIR SHOULDER CAPSULE | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 23466 | REPAIR SHOULDER CAPSULE | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 23470 | RECONSTRUCT SHOULDER JOINT | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 23472 | RECONSTRUCT SHOULDER JOINT | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 23473 | REVIS RECONST SHOULDER JOINT | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 23474 | REVIS RECONST SHOULDER JOINT | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 24587 | TREAT ELBOW FRACTURE | Pre-operative evaluation, history and physical including functional impairment, and operative report. |
| 25310 | TRANSPLANT FOREARM TENDON | Pre-operative evaluation, history and physical including functional impairment, and operative report. |
| 25312 | TRANSPLANT FOREARM TENDON | Pre-operative evaluation, history and physical including functional impairment, and operative report. |
| 26480 | TRANSPLANT HAND TENDON | Pre-operative evaluation, history and physical including functional impairment, and operative report. |
| 26483 | TRANSPLANT/GRAFT HAND TENDON | Pre-operative evaluation, history and physical including functional impairment, and operative report. |
| 26485 | TRANSPLANT PALM TENDON | Pre-operative evaluation, history and physical including functional impairment, and operative report. |
| 26489 | TRANSPLANT/GRAFT PALM TENDON | Pre-operative evaluation, history and physical including functional impairment, and operative report. |
| 27096 | INJECT SACROILIAC JOINT | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 27125 | PARTIAL HIP REPLACEMENT | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 27130 | TOTAL HIP ARTHROPLASTY | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 27132 | TOTAL HIP ARTHROPLASTY | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 27134 | REVISE HIP JOINT REPLACEMENT | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |

| CPT and HCPCS Codes That May Require Prior Authorization | Description of Procedure Code | Medical Records Request Information Required |
|--|-------------------------------|---|
| 27137 | REVISE HIP JOINT REPLACEMENT | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 27138 | REVISE HIP JOINT REPLACEMENT | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 27279 | ARTHRODESIS SACROILIAC JOINT | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 27280 | FUSION OF SACROILIAC JOINT | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 27332 | REMOVAL OF KNEE CARTILAGE | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 27333 | REMOVAL OF KNEE CARTILAGE | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 27334 | REMOVE KNEE JOINT LINING | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 27335 | REMOVE KNEE JOINT LINING | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 27396 | TRANSPLANT OF THIGH TENDON | Pre-operative evaluation, history and physical including functional impairment, and operative report. |
| 27397 | TRANSPLANTS OF THIGH TENDONS | Pre-operative evaluation, history and physical including functional impairment, and operative report. |
| 27403 | REPAIR OF KNEE CARTILAGE | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 27405 | REPAIR OF KNEE LIGAMENT | Pre-operative evaluation, history and physical including functional impairment, and operative report. |
| 27407 | REPAIR OF KNEE LIGAMENT | Pre-operative evaluation, history and physical including functional impairment, and operative report. |
| 27409 | REPAIR OF KNEE LIGAMENTS | Pre-operative evaluation, history and physical including functional impairment, and operative report. |
| 27412 | AUTOCHONDROCYTE IMPLANT KNEE | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 27415 | OSTEOCHONDRAL KNEE ALLOGRAFT | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 27416 | OSTEOCHONDRAL KNEE AUTOGRAFT | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 27418 | REPAIR DEGENERATED KNEECAP | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 27420 | REVISION OF UNSTABLE KNEECAP | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |

| CPT and HCPCS Codes That May Require Prior Authorization | Description of Procedure Code | Medical Records Request Information Required |
|--|-------------------------------|---|
| 27422 | REVISION OF UNSTABLE KNEECAP | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 27424 | REVISION/REMOVAL OF KNEECAP | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 27425 | LAT RETINACULAR RELEASE OPEN | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 27427 | RECONSTRUCTION KNEE | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 27428 | RECONSTRUCTION KNEE | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 27429 | RECONSTRUCTION KNEE | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 27430 | REVISION OF THIGH MUSCLES | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 27438 | REVISE KNEECAP WITH IMPLANT | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 27440 | REVISION OF KNEE JOINT | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 27441 | REVISION OF KNEE JOINT | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 27442 | REVISION OF KNEE JOINT | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 27443 | REVISION OF KNEE JOINT | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 27445 | REVISION OF KNEE JOINT | Pre-operative evaluation, history and physical including functional impairment, and operative report. |
| 27446 | REVISION OF KNEE JOINT | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 27447 | TOTAL KNEE ARTHROPLASTY | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 27486 | REVISE/REPLACE KNEE JOINT | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 27487 | REVISE/REPLACE KNEE JOINT | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 27557 | TREAT KNEE DISLOCATION | Pre-operative evaluation, history and physical including functional impairment, and operative report. |
| 27558 | TREAT KNEE DISLOCATION | Pre-operative evaluation, history and physical including functional impairment, and operative report. |
| 27690 | REVISE LOWER LEG TENDON | Pre-operative evaluation, history and physical including functional impairment, and operative report. |

| CPT and HCPCS Codes That May Require Prior Authorization | Description of Procedure Code | Medical Records Request Information Required |
|--|-------------------------------|---|
| 27691 | REVISE LOWER LEG TENDON | Pre-operative evaluation, history and physical including functional impairment, and operative report. |
| 27692 | REVISE ADDITIONAL LEG TENDON | Pre-operative evaluation, history and physical including functional impairment, and operative report. |
| 28292 | CORRECTION HALLUX VALGUS | Pre-operative evaluation, history and physical including functional impairment, and operative report. |
| 28890 | HI ENRGY ESWT PLANTAR FASCIA | Pre-operative evaluation, history and physical including functional impairment, and operative report. |
| 29805 | SHOULDER ARTHROSCOPY DX | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 29806 | SHOULDER ARTHROSCOPY/SURGERY | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 29807 | SHOULDER ARTHROSCOPY/SURGERY | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 29819 | SHOULDER ARTHROSCOPY/SURGERY | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 29820 | SHOULDER ARTHROSCOPY/SURGERY | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 29821 | SHOULDER ARTHROSCOPY/SURGERY | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 29822 | SHOULDER ARTHROSCOPY/SURGERY | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 29823 | SHOULDER ARTHROSCOPY/SURGERY | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 29824 | SHOULDER ARTHROSCOPY/SURGERY | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 29825 | SHOULDER ARTHROSCOPY/SURGERY | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 29826 | SHOULDER ARTHROSCOPY/SURGERY | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 29827 | ARTHROSCOP ROTATOR CUFF REPR | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 29828 | ARTHROSCOPY BICEPS TENODESIS | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 29860 | HIP ARTHROSCOPY DX | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 29861 | HIP ARTHRO W/FB REMOVAL | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 29862 | HIP ARTHRO W/DEBRIDEMENT | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |

| CPT and HCPCS Codes That May Require Prior Authorization | Description of Procedure Code | Medical Records Request Information Required |
|--|-------------------------------|---|
| 29863 | HIP ARTHRO W/SYNOVECTOMY | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 29866 | AUTGRFT IMPLNT KNEE W/SCOPE | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 29867 | ALLGRFT IMPLNT KNEE W/SCOPE | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 29868 | MENISCAL TRNSPL KNEE W/SCPE | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 29870 | KNEE ARTHROSCOPY DX | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 29871 | KNEE ARTHROSCOPY/DRAINAGE | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 29873 | KNEE ARTHROSCOPY/SURGERY | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 29874 | KNEE ARTHROSCOPY/SURGERY | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 29875 | KNEE ARTHROSCOPY/SURGERY | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 29876 | KNEE ARTHROSCOPY/SURGERY | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 29877 | KNEE ARTHROSCOPY/SURGERY | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 29879 | KNEE ARTHROSCOPY/SURGERY | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 29880 | KNEE ARTHROSCOPY/SURGERY | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 29881 | KNEE ARTHROSCOPY/SURGERY | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 29882 | KNEE ARTHROSCOPY/SURGERY | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 29883 | KNEE ARTHROSCOPY/SURGERY | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 29884 | KNEE ARTHROSCOPY/SURGERY | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 29885 | KNEE ARTHROSCOPY/SURGERY | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 29886 | KNEE ARTHROSCOPY/SURGERY | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 29887 | KNEE ARTHROSCOPY/SURGERY | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 29888 | KNEE ARTHROSCOPY/SURGERY | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 29889 | KNEE ARTHROSCOPY/SURGERY | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |

| CPT and HCPCS Codes That May Require Prior Authorization | Description of Procedure Code | Medical Records Request Information Required |
|--|-------------------------------|---|
| 29914 | HIP ARTHRO W/FEMOROPLASTY | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 29915 | HIP ARTHRO ACETABULOPLASTY | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 29916 | HIP ARTHRO W/LABRAL REPAIR | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 30400 | RECONSTRUCTION OF NOSE | Pre-operative evaluation, history and physical including functional impairment, and operative report. |
| 30410 | RECONSTRUCTION OF NOSE | Pre-operative evaluation, history and physical including functional impairment, and operative report. |
| 30420 | RECONSTRUCTION OF NOSE | Pre-operative evaluation, history and physical including functional impairment, and operative report. |
| 30430 | REVISION OF NOSE | Pre-operative evaluation, history and physical including functional impairment, and operative report. |
| 30435 | REVISION OF NOSE | Pre-operative evaluation, history and physical including functional impairment, and operative report. |
| 30450 | REVISION OF NOSE | Pre-operative evaluation, history and physical including functional impairment, and operative report. |
| 30460 | REVISION OF NOSE | Pre-operative evaluation, history and physical including functional impairment, and operative report. |
| 30462 | REVISION OF NOSE | Pre-operative evaluation, history and physical including functional impairment, and operative report. |
| 30520 | REPAIR OF NASAL SEPTUM | Pre-operative evaluation, history and physical including functional impairment, and operative report. |
| 30801 | ABLATE INF TURBINATE SUPERF | Pre-operative evaluation, history and physical including functional impairment, and operative report. |
| 30802 | ABLATE INF TURBINATE SUBMUC | Pre-operative evaluation, history and physical including functional impairment, and operative report. |
| 31575 | DIAGNOSTIC LARYNGOSCOPY | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 31579 | LARYNGOSCOPY TELESCOPIC | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |

| CPT and HCPCS Codes That May Require Prior Authorization | Description of Procedure Code | Medical Records Request Information Required |
|--|-------------------------------|---|
| 31600 | INCISION OF WINDPIPE | Pre-operative evaluation, history and physical including functional impairment, and operative report. |
| 31830 | REVISE WINDPIPE SCAR | Pre-operative evaluation, history and physical including functional impairment, and operative report. |
| 32850 | DONOR PNEUMONECTOMY | Pre-operative evaluation, history and physical including functional impairment, and operative report. |
| 32851 | LUNG TRANSPLANT SINGLE | If transplant approval on record: Date of transplant If no transplant approval: history and physical, transplant evaluation, and date of transplant. |
| 32852 | LUNG TRANSPLANT WITH BYPASS | If transplant approval on record: Date of transplant If no transplant approval: history and physical, transplant evaluation, and date of transplant. |
| 32853 | LUNG TRANSPLANT DOUBLE | If transplant approval on record: Date of transplant If no transplant approval: history and physical, transplant evaluation, and date of transplant. |
| 32854 | LUNG TRANSPLANT WITH BYPASS | If transplant approval on record: Date of transplant If no transplant approval: history and physical, transplant evaluation, and date of transplant. |
| 32855 | PREPARE DONOR LUNG SINGLE | If transplant approval on record: Date of transplant If no transplant approval: history and physical, transplant evaluation, and date of transplant. |
| 32856 | PREPARE DONOR LUNG DOUBLE | If transplant approval on record: Date of transplant If no transplant approval: history and physical, transplant evaluation, and date of transplant. |
| 33249 | INSJ/RPLCMT DEFIB W/LEAD(S) | Letter of medical necessity, including condition being treated. |
| 33405 | REPLACEMENT AORTIC VALVE OPN | Letter of medical necessity, including condition being treated. |
| 33430 | REPLACEMENT OF MITRAL VALVE | Letter of medical necessity, including condition being treated. |
| 33933 | PREPARE DONOR HEART/LUNG | If transplant approval on record: Date of transplant If no transplant approval: history and physical, transplant evaluation, and date of transplant. |
| 33935 | TRANSPLANTATION HEART/LUNG | If transplant approval on record: Date of transplant If no transplant approval: history and physical, transplant evaluation, and date of transplant. |
| 33944 | PREPARE DONOR HEART | If transplant approval on record: Date of transplant If no transplant approval: history and physical, transplant evaluation, and date of transplant. |

| CPT and HCPCS Codes That May Require Prior Authorization | Description of Procedure Code | Medical Records Request Information Required |
|--|-------------------------------|---|
| 33945 | TRANSPLANTATION OF HEART | If transplant approval on record: Date of transplant If no transplant approval: history and physical, transplant evaluation, and date of transplant. |
| 35879 | REVISE GRAFT W/VEIN | If transplant approval on record: Date of transplant If no transplant approval: history and physical, transplant evaluation, and date of transplant. |
| 36468 | NJX SCLRSNT SPIDER VEINS | Pre-operative evaluation, history and physical including functional impairment, and operative report. |
| 36469 | NJX SCLRSNT SPIDER VEINS | Pre-operative evaluation, history and physical including functional impairment, and operative report. |
| 36470 | NJX SCLRSNT 1 INCMPTNT VEIN | Pre-operative evaluation, history and physical including functional impairment, and operative report. |
| 37220 | ILIAC REVASC | Pre-operative evaluation, history and physical including results of Doppler studies, and operative report. |
| 37224 | FEM/POPL REVAS W/TLA | Pre-operative evaluation, history and physical including results of Doppler studies, and operative report. |
| 37227 | FEM/POPL REVASC STNT & ATHER | Letter of medical necessity, including condition being treated. |
| 37228 | TIB/PER REVASC W/TLA | Pre-operative evaluation, history and physical including results of Doppler studies, and operative report. |
| 37241 | VASC EMBOLIZE/OCCLUDE VENOUS | Pre-operative evaluation, history and physical including results of Doppler studies, and operative report. |
| 37243 | VASC EMBOLIZE/OCCLUDE ORGAN | Letter of medical necessity, including condition being treated. |
| 37500 | ENDOSCOPY LIGATE PERF VEINS | Pre-operative evaluation, history and physical and operative report. |
| 37565 | LIGATION OF NECK VEIN | Pre-operative evaluation, history and physical and operative report. |
| 37650 | REVISION OF MAJOR VEIN | Pre-operative evaluation, history and physical and operative report. |
| 37700 | REVISE LEG VEIN | Pre-operative evaluation, history and physical and operative report. |
| 37718 | LIGATE/STRIP SHORT LEG VEIN | Pre-operative evaluation, history and physical and operative report. |
| 37722 | LIGATE/STRIP LONG LEG VEIN | Pre-operative evaluation, history and physical and operative report. |

| CPT and HCPCS Codes That May Require Prior Authorization | Description of Procedure Code | Medical Records Request Information Required |
|--|-------------------------------|---|
| 37735 | REMOVAL OF LEG VEINS/LESION | Pre-operative evaluation, history and physical and operative report. |
| 37760 | LIGATE LEG VEINS RADICAL | History and physical and operative report. |
| 37761 | LIGATE LEG VEINS OPEN | History and physical and operative report. |
| 37780 | REVISION OF LEG VEIN | Pre-operative evaluation, history and physical and operative report. |
| 37785 | LIGATE/DIVIDE/EXCISE VEIN | Pre-operative evaluation, history and physical and operative report. |
| 38204 | BL DONOR SEARCH MANAGEMENT | If transplant approval on record: Date of transplant If no transplant approval: history and physical, transplant evaluation, and date of transplant. |
| 38205 | HARVEST ALLOGENEIC STEM CELL | If transplant approval on record: Date of transplant If no transplant approval: history and physical, transplant evaluation, and date of transplant. |
| 38206 | HARVEST AUTO STEM CELLS | If transplant approval on record: Date of transplant If no transplant approval: history and physical, transplant evaluation, and date of transplant. |
| 38207 | CRYOPRESERVE STEM CELLS | If transplant approval on record: Date of transplant If no transplant approval: history and physical, transplant evaluation, and date of transplant. |
| 38208 | THAW PRESERVED STEM CELLS | If transplant approval on record: Date of transplant If no transplant approval: history and physical, transplant evaluation, and date of transplant. |
| 38209 | WASH HARVEST STEM CELLS | If transplant approval on record: Date of transplant If no transplant approval: history and physical, transplant evaluation, and date of transplant. |
| 38210 | T-CELL DEPLETION OF HARVEST | If transplant approval on record: Date of transplant If no transplant approval: history and physical, transplant evaluation, and date of transplant. |
| 38211 | TUMOR CELL DEplete OF HARVEST | If transplant approval on record: Date of transplant If no transplant approval: history and physical, transplant evaluation, and date of transplant. |
| 38212 | RBC DEPLETION OF HARVEST | If transplant approval on record: Date of transplant If no transplant approval: history and physical, transplant evaluation, and date of transplant. |
| 38213 | PLATELET DEplete OF HARVEST | If transplant approval on record: Date of transplant If no transplant approval: history and physical, transplant evaluation, and date of transplant. |
| 38214 | VOLUME DEplete OF HARVEST | If transplant approval on record: Date of transplant If no transplant approval: history and physical, transplant evaluation, and date of transplant. |
| 38215 | HARVEST STEM CELL CONCENTRATE | If transplant approval on record: Date of transplant If no transplant approval: history and physical, transplant evaluation, and date of transplant. |

| CPT and HCPCS Codes That May Require Prior Authorization | Description of Procedure Code | Medical Records Request Information Required |
|--|-------------------------------|---|
| 38230 | BONE MARROW HARVEST ALLOGEN | If transplant approval on record: Date of transplant If no transplant approval: history and physical, transplant evaluation, and date of transplant. |
| 38232 | BONE MARROW HARVEST AUTOLOG | If transplant approval on record: Date of transplant If no transplant approval: history and physical, transplant evaluation, and date of transplant. |
| 38240 | TRANSPLT ALLO HCT/DONOR | If transplant approval on record: Date of transplant If no transplant approval: history and physical, transplant evaluation, and date of transplant. |
| 38241 | TRANSPLT AUTOL HCT/DONOR | If transplant approval on record: Date of transplant If no transplant approval: history and physical, transplant evaluation, and date of transplant. |
| 38242 | TRANSPLT ALLO LYMPHOCYTES | If transplant approval on record: Date of transplant If no transplant approval: history and physical, transplant evaluation, and date of transplant. |
| 40700 | REPAIR CLEFT LIP/NASAL | History and physical and operative report. |
| 40701 | REPAIR CLEFT LIP/NASAL | History and physical and operative report. |
| 40702 | REPAIR CLEFT LIP/NASAL | History and physical and operative report. |
| 40720 | REPAIR CLEFT LIP/NASAL | History and physical and operative report. |
| 40761 | REPAIR CLEFT LIP/NASAL | History and physical and operative report. |
| 40820 | TREATMENT OF MOUTH LESION | History and physical and operative report. |
| 41120 | PARTIAL REMOVAL OF TONGUE | History and physical and operative report. |
| 41512 | TONGUE SUSPENSION | History and physical and operative report. |
| 41530 | TONGUE BASE VOL REDUCTION | History and physical, including sleep study results, results of CPAP trial. |
| 42140 | EXCISION OF UVULA | History and physical and operative report. |
| 42145 | REPAIR PALATE PHARYNX/UVULA | History and physical, including sleep study results, results of CPAP trial. |
| 42200 | RECONSTRUCT CLEFT PALATE | History and physical and operative report. |
| 42205 | RECONSTRUCT CLEFT PALATE | History and physical and operative report. |
| 42210 | RECONSTRUCT CLEFT PALATE | History and physical and operative report. |
| 42215 | RECONSTRUCT CLEFT PALATE | History and physical and operative report. |
| 42220 | RECONSTRUCT CLEFT PALATE | History and physical and operative report. |
| 42225 | RECONSTRUCT CLEFT PALATE | History and physical and operative report. |
| 43112 | ESPHG TOT W/THRCM | History and physical and operative report. |
| 43121 | PARTIAL REMOVAL OF ESOPHAGUS | History and physical and operative report. |
| 43122 | PARTIAL REMOVAL OF ESOPHAGUS | History and physical and operative report. |
| 43236 | UPPR GI SCOPE W/SUBMUC INJ | History and physical and operative report. |
| 43360 | GASTROINTESTINAL REPAIR | History and physical and operative report. |
| 43633 | REMOVAL OF STOMACH PARTIAL | History and physical and operative report. |
| 43644 | LAP GASTRIC BYPASS/ROUX-EN-Y | History and physical, nutritional evaluation, psychological evaluation, weight loss attempts, social supports. |

| CPT and HCPCS Codes That May Require Prior Authorization | Description of Procedure Code | Medical Records Request Information Required |
|--|-------------------------------|--|
| 43645 | LAP GASTR BYPASS INCL SMLL I | History and physical, nutritional evaluation, psychological evaluation, weight loss attempts, social supports. |
| 43659 | LAPAROSCOPE PROC STOM | Letter of medical necessity, including condition being treated. |
| 43770 | LAP PLACE GASTR ADJ DEVICE | History and physical, nutritional evaluation, psychological evaluation, weight loss attempts, social supports. |
| 43771 | LAP REVISE GASTR ADJ DEVICE | History and physical, nutritional evaluation, psychological evaluation, weight loss attempts, social supports. |
| 43772 | LAP RMVL GASTR ADJ DEVICE | History and physical, nutritional evaluation, psychological evaluation, weight loss attempts, social supports. |
| 43773 | LAP REPLACE GASTR ADJ DEVICE | History and physical, nutritional evaluation, psychological evaluation, weight loss attempts, social supports. |
| 43774 | LAP RMVL GASTR ADJ ALL PARTS | History and physical, nutritional evaluation, psychological evaluation, weight loss attempts, social supports. |
| 43775 | LAP SLEEVE GASTRECTOMY | History and physical, nutritional evaluation, psychological evaluation, weight loss attempts, social supports. |
| 43800 | RECONSTRUCTION OF PYLORUS | History and physical, nutritional evaluation, psychological evaluation, weight loss attempts, social supports. |
| 43842 | V-BAND GASTROPLASTY | History and physical, nutritional evaluation, psychological evaluation, weight loss attempts, social supports. |
| 43843 | GASTROPLASTY W/O V-BAND | History and physical, nutritional evaluation, psychological evaluation, weight loss attempts, social supports. |
| 43845 | GASTROPLASTY DUODENAL SWITCH | History and physical, nutritional evaluation, psychological evaluation, weight loss attempts, social supports. |
| 43846 | GASTRIC BYPASS FOR OBESITY | History and physical, nutritional evaluation, psychological evaluation, weight loss attempts, social supports. |
| 43847 | GASTRIC BYPASS INCL SMALL I | History and physical, nutritional evaluation, psychological evaluation, weight loss attempts, social supports. |
| 43848 | REVISION GASTROPLASTY | History and physical, nutritional evaluation, psychological evaluation, weight loss attempts, social supports. |

| CPT and HCPCS Codes That May Require Prior Authorization | Description of Procedure Code | Medical Records Request Information Required |
|--|-------------------------------|---|
| 43886 | REVISE GASTRIC PORT OPEN | History and physical, nutritional evaluation, psychological evaluation, weight loss attempts, social supports. |
| 43887 | REMOVE GASTRIC PORT OPEN | History and physical, nutritional evaluation, psychological evaluation, weight loss attempts, social supports. |
| 43888 | CHANGE GASTRIC PORT OPEN | history and physical, nutritional evaluation, psychological evaluation, weight loss attempts, social supports. |
| 43999 | STOMACH SURGERY PROCEDURE | If transplant approval on record: Date of Transplant If no Transplant approval: history and physical, transplant evaluation, and date of transplant. |
| 44132 | ENTERECTOMY CADAVER DONOR | If transplant approval on record: Date of Transplant If no Transplant approval: history and physical, transplant evaluation, and date of transplant. |
| 44133 | ENTERECTOMY LIVE DONOR | If transplant approval on record: Date of Transplant If no Transplant approval: history and physical, transplant evaluation, and date of transplant. |
| 44135 | INTESTINE TRANSPLNT CADAVER | If transplant approval on record: Date of Transplant If no Transplant approval: history and physical, transplant evaluation, and date of transplant. |
| 44136 | INTESTINE TRANSPLANT LIVE | If transplant approval on record: Date of Transplant If no Transplant approval: history and physical, transplant evaluation, and date of transplant. |
| 44137 | REMOVE INTESTINAL ALLOGRAFT | If transplant approval on record: Date of Transplant If no Transplant approval: history and physical, transplant evaluation, and date of transplant. |
| 44715 | PREPARE DONOR INTESTINE | If transplant approval on record: Date of Transplant If no Transplant approval: history and physical, transplant evaluation, and date of transplant. |
| 44720 | PREP DONOR INTESTINE/VENOUS | If transplant approval on record: Date of Transplant If no Transplant approval: history and physical, transplant evaluation, and date of transplant. |
| 44721 | PREP DONOR INTESTINE/ARTERY | If transplant approval on record: Date of Transplant If no Transplant approval: history and physical, transplant evaluation, and date of transplant. |
| 45126 | PELVIC EXENTERATION | History and physical and procedure report. |
| 46760 | REPAIR OF ANAL SPHINCTER | History and physical and procedure report. |
| 47120 | PARTIAL REMOVAL OF LIVER | History and physical and procedure report. |
| 47122 | EXTENSIVE REMOVAL OF LIVER | History and physical and procedure report. |
| 47125 | PARTIAL REMOVAL OF LIVER | History and physical and procedure report. |
| 47130 | PARTIAL REMOVAL OF LIVER | History and physical and procedure report. |

| CPT and HCPCS Codes That May Require Prior Authorization | Description of Procedure Code | Medical Records Request Information Required |
|--|-------------------------------|---|
| 47133 | REMOVAL OF DONOR LIVER | If transplant approval on record: Date of Transplant If no Transplant approval: history and physical, transplant evaluation, and date of transplant. |
| 47135 | TRANSPLANTATION OF LIVER | If transplant approval on record: Date of Transplant If no Transplant approval: history and physical, transplant evaluation, and date of transplant. |
| 47140 | PARTIAL REMOVAL DONOR LIVER | If transplant approval on record: Date of Transplant If no Transplant approval: history and physical, transplant evaluation, and date of transplant. |
| 47141 | PARTIAL REMOVAL DONOR LIVER | If transplant approval on record: Date of Transplant If no Transplant approval: history and physical, transplant evaluation, and date of transplant. |
| 47142 | PARTIAL REMOVAL DONOR LIVER | If transplant approval on record: Date of Transplant If no Transplant approval: history and physical, transplant evaluation, and date of transplant. |
| 47143 | PREP DONOR LIVER WHOLE | If transplant approval on record: Date of Transplant If no Transplant approval: history and physical, transplant evaluation, and date of transplant. |
| 47144 | PREP DONOR LIVER 3-SEGMENT | If transplant approval on record: Date of Transplant If no Transplant approval: history and physical, transplant evaluation, and date of transplant. |
| 47145 | PREP DONOR LIVER LOBE SPLIT | If transplant approval on record: Date of Transplant If no Transplant approval: history and physical, transplant evaluation, and date of transplant. |
| 47146 | PREP DONOR LIVER/VENOUS | If transplant approval on record: Date of Transplant If no Transplant approval: history and physical, transplant evaluation, and date of transplant. |
| 47147 | PREP DONOR LIVER/ARTERIAL | If transplant approval on record: Date of Transplant If no Transplant approval: history and physical, transplant evaluation, and date of transplant. |
| 47420 | INCISION OF BILE DUCT | If transplant approval on record: Date of Transplant If no Transplant approval: history and physical, transplant evaluation, and date of transplant. |
| 47425 | INCISION OF BILE DUCT | If transplant approval on record: Date of Transplant If no Transplant approval: history and physical, transplant evaluation, and date of transplant. |
| 48160 | PANCREAS REMOVAL/TRANSPLANT | If transplant approval on record: Date of Transplant If no Transplant approval: history and physical, transplant evaluation, and date of transplant. |
| 48550 | DONOR PANCREATECTOMY | If transplant approval on record: Date of Transplant If no Transplant approval: history and physical, transplant evaluation, and date of transplant. |

| CPT and HCPCS Codes That May Require Prior Authorization | Description of Procedure Code | Medical Records Request Information Required |
|--|-------------------------------|---|
| 48551 | PREP DONOR PANCREAS | If transplant approval on record: Date of Transplant If no Transplant approval: history and physical, transplant evaluation, and date of transplant. |
| 48552 | PREP DONOR PANCREAS/VENOUS | If transplant approval on record: Date of Transplant If no Transplant approval: history and physical, transplant evaluation, and date of transplant. |
| 48554 | TRANSPL ALLOGRAFT PANCREAS | If transplant approval on record: Date of Transplant If no Transplant approval: history and physical, transplant evaluation, and date of transplant. |
| 48556 | REMOVAL ALLOGRAFT PANCREAS | If transplant approval on record: Date of Transplant If no Transplant approval: history and physical, transplant evaluation, and date of transplant. |
| 50300 | REMOVE CADAVER DONOR KIDNEY | If transplant approval on record: Date of Transplant If no Transplant approval: history and physical, transplant evaluation, and date of transplant. |
| 50320 | REMOVE KIDNEY LIVING DONOR | If transplant approval on record: Date of Transplant If no Transplant approval: history and physical, transplant evaluation, and date of transplant. |
| 50323 | PREP CADAVER RENAL ALLOGRAFT | If transplant approval on record: Date of Transplant If no Transplant approval: history and physical, transplant evaluation, and date of transplant. |
| 50325 | PREP DONOR RENAL GRAFT | If transplant approval on record: Date of Transplant If no Transplant approval: history and physical, transplant evaluation, and date of transplant. |
| 50327 | PREP RENAL GRAFT/VENOUS | If transplant approval on record: Date of Transplant If no Transplant approval: history and physical, transplant evaluation, and date of transplant. |
| 50328 | PREP RENAL GRAFT/ARTERIAL | If transplant approval on record: Date of Transplant If no Transplant approval: history and physical, transplant evaluation, and date of transplant. |
| 50329 | PREP RENAL GRAFT/URETERAL | If transplant approval on record: Date of Transplant If no Transplant approval: history and physical, transplant evaluation, and date of transplant. |
| 50340 | REMOVAL OF KIDNEY | If transplant approval on record: Date of Transplant If no Transplant approval: history and physical, transplant evaluation, and date of transplant. |
| 50360 | TRANSPLANTATION OF KIDNEY | If transplant approval on record: Date of Transplant If no Transplant approval: history and physical, transplant evaluation, and date of transplant. |
| 50365 | TRANSPLANTATION OF KIDNEY | If transplant approval on record: Date of Transplant If no Transplant approval: history and physical, transplant evaluation, and date of transplant. |

| CPT and HCPCS Codes That May Require Prior Authorization | Description of Procedure Code | Medical Records Request Information Required |
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| 50370 | REMOVE TRANSPLANTED KIDNEY | If transplant approval on record: Date of Transplant If no Transplant approval: history and physical, transplant evaluation, and date of transplant. |
| 50380 | REIMPLANTATION OF KIDNEY | If transplant approval on record: Date of Transplant If no Transplant approval: history and physical, transplant evaluation, and date of transplant. |
| 50544 | LAPAROSCOPY PYELOPLASTY | If transplant approval on record: Date of Transplant If no Transplant approval: history and physical, transplant evaluation, and date of transplant. |
| 50860 | TRANSPLANT URETER TO SKIN | If transplant approval on record: Date of Transplant If no Transplant approval: history and physical, transplant evaluation, and date of transplant. |
| 51580 | REMOVE BLADDER/REVISE TRACT | If transplant approval on record: Date of Transplant If no Transplant approval: history and physical, transplant evaluation, and date of transplant. |
| 51585 | REMOVAL OF BLADDER & NODES | Submit history and physical, documentation of medical necessity, operative report. |
| 51597 | REMOVAL OF PELVIC STRUCTURES | Submit history and physical, documentation of medical necessity, operative report. |
| 53430 | RECONSTRUCTION OF URETHRA | Submit history and physical, documentation of medical necessity, operative report. |
| 54125 | REMOVAL OF PENIS | Submit history and physical, documentation of medical necessity, operative report. |
| 54304 | REVISION OF PENIS | Submit history and physical, documentation of medical necessity, operative report. |
| 54400 | INSERT SEMI-RIGID PROSTHESIS | Submit history and physical, documentation of medical necessity, operative report. |
| 54401 | INSERT SELF-CONTD PROSTHESIS | Submit history and physical, documentation of medical necessity, operative report. |
| 54405 | INSERT MULTI-COMP PENIS PROS | Submit history and physical, documentation of medical necessity, operative report. |
| 54406 | REMOVE MUTI-COMP PENIS PROS | Submit history and physical, documentation of medical necessity, operative report. |
| 54408 | REPAIR MULTI-COMP PENIS PROS | Submit history and physical, documentation of medical necessity, operative report. |
| 54410 | REMOVE/REPLACE PENIS PROSTH | Submit history and physical, documentation of medical necessity, operative report. |
| 54411 | REMOV/REPLC PENIS PROS COMP | Submit history and physical, documentation of medical necessity, operative report. |
| 54415 | REMOVE SELF-CONTD PENIS PROS | Submit history and physical, documentation of medical necessity, operative report. |
| 54416 | REMOV/REPL PENIS CONTAIN PROS | Submit history and physical, documentation of medical necessity, operative report. |

| CPT and HCPCS Codes That May Require Prior Authorization | Description of Procedure Code | Medical Records Request Information Required |
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| 54417 | REMOV/REPLC PENIS PROS COMPL | Submit history and physical, documentation of medical necessity, operative report. |
| 54520 | REMOVAL OF TESTIS | Submit history and physical, documentation of medical necessity, operative report. |
| 54660 | REVISION OF TESTIS | Submit history and physical, documentation of medical necessity, operative report. |
| 55175 | REVISION OF SCROTUM | Submit history and physical, documentation of medical necessity, operative report. |
| 55180 | REVISION OF SCROTUM | Submit history and physical, documentation of medical necessity, operative report. |
| 55970 | SEX TRANSFORMATION M TO F | Submit history and physical, documentation of medical necessity, operative report. |
| 55980 | SEX TRANSFORMATION F TO M | Submit history and physical, documentation of medical necessity, operative report. |
| 56625 | COMPLETE REMOVAL OF VULVA | Submit history and physical, documentation of medical necessity, operative report. |
| 56800 | REPAIR OF VAGINA | Submit history and physical, documentation of medical necessity, operative report. |
| 56805 | REPAIR CLITORIS | Submit history and physical, documentation of medical necessity, operative report. |
| 56810 | REPAIR OF PERINEUM | Submit history and physical, documentation of medical necessity, operative report. |
| 57106 | REMOVE VAGINA WALL PARTIAL | Submit history and physical, documentation of medical necessity, operative report. |
| 57107 | REMOVE VAGINA TISSUE PART | Submit history and physical, documentation of medical necessity, operative report. |
| 57110 | REMOVE VAGINA WALL COMPLETE | Submit history and physical, documentation of medical necessity, operative report. |
| 57111 | REMOVE VAGINA TISSUE COMPL | Submit history and physical, documentation of medical necessity, operative report. |
| 57288 | REPAIR BLADDER DEFECT | Letter of medical necessity, including condition being treated. |
| 57291 | CONSTRUCTION OF VAGINA | Submit history and physical, documentation of medical necessity, operative report. |
| 57292 | CONSTRUCT VAGINA WITH GRAFT | Submit history and physical, documentation of medical necessity, operative report. |
| 57295 | REVISE VAG GRAFT VIA VAGINA | Submit history and physical, documentation of medical necessity, operative report. |
| 57296 | REVISE VAG GRAFT OPEN ABD | Submit history and physical, documentation of medical necessity, operative report. |
| 57311 | REPAIR URETHROVAGINAL LESION | Submit history and physical, documentation of medical necessity, operative report. |
| 57335 | REPAIR VAGINA | Submit history and physical, documentation of medical necessity, operative report. |

| CPT and HCPCS Codes That May Require Prior Authorization | Description of Procedure Code | Medical Records Request Information Required |
|---|--------------------------------------|--|
| 57426 | REVISE PROSTH VAG GRAFT LAP | Submit history and physical, documentation of medical necessity, operative report. |
| 58150 | TOTAL HYSTERECTOMY | Submit history and physical, documentation of medical necessity, operative report. |
| 58180 | PARTIAL HYSTERECTOMY | Submit history and physical, documentation of medical necessity, operative report. |
| 58240 | REMOVAL OF PELVIS CONTENTS | Submit history and physical, documentation of medical necessity, operative report. |
| 58260 | VAGINAL HYSTERECTOMY | Submit history and physical, documentation of medical necessity, operative report. |
| 58262 | VAG HYST INCLUDING T/O | Submit history and physical, documentation of medical necessity, operative report. |
| 58275 | HYSTERECTOMY/REVISE VAGINA | Submit history and physical, documentation of medical necessity, operative report. |
| 58280 | HYSTERECTOMY/REVISE VAGINA | Submit history and physical, documentation of medical necessity, operative report. |
| 58285 | EXTENSIVE HYSTERECTOMY | Submit history and physical, documentation of medical necessity, operative report. |
| 58290 | VAG HYST COMPLEX | Submit history and physical, documentation of medical necessity, operative report. |
| 58291 | VAG HYST INCL T/O COMPLEX | Submit history and physical, documentation of medical necessity, operative report. |
| 58541 | LSH UTERUS 250 G OR LESS | Submit history and physical, documentation of medical necessity, operative report. |
| 58542 | LSH W/T/O UT 250 G OR LESS | Submit history and physical, documentation of medical necessity, operative report. |
| 58543 | LSH UTERUS ABOVE 250 G | Submit history and physical, documentation of medical necessity, operative report. |
| 58544 | LSH W/T/O UTERUS ABOVE 250 G | Submit history and physical, documentation of medical necessity, operative report. |
| 58550 | LAPARO-ASST VAG HYSTERECTOMY | Submit history and physical, documentation of medical necessity, operative report. |
| 58552 | LAPARO-VAG HYST INCL T/O | Submit history and physical, documentation of medical necessity, operative report. |
| 58553 | LAPARO-VAG HYST COMPLEX | Submit history and physical, documentation of medical necessity, operative report. |
| 58554 | LAPARO-VAG HYST W/T/O COMPL | Submit history and physical, documentation of medical necessity, operative report. |
| 58570 | TLH UTERUS 250 G OR LESS | Submit history and physical, documentation of medical necessity, operative report. |
| 58571 | TLH W/T/O 250 G OR LESS | Submit history and physical, documentation of medical necessity, operative report. |
| 58572 | TLH UTERUS OVER 250 G | Submit history and physical, documentation of medical necessity, operative report. |

| CPT and HCPCS Codes That May Require Prior Authorization | Description of Procedure Code | Medical Records Request Information Required |
|--|-------------------------------|--|
| 58573 | TLH W/T/O UTERUS OVER 250 G | Submit history and physical, documentation of medical necessity, operative report. |
| 58670 | LAPAROSCOPY TUBAL CAUTERY | Letter of medical necessity, including condition being treated. |
| 58672 | LAPAROSCOPY FIMBRIOPLASTY | Submit history and physical, documentation of medical necessity, operative report. |
| 58720 | REMOVAL OF OVARY/TUBE(S) | Submit history and physical, documentation of medical necessity, operative report. |
| 58760 | FIMBRIOPLASTY | Submit history and physical, documentation of medical necessity, operative report. |
| 60512 | AUTOTRANSPLANT PARATHYROID | Submit history and physical, documentation of medical necessity including operative report. |
| 62115 | REDUCTION OF SKULL DEFECT | Submit history and physical, documentation of medical necessity including operative report. |
| 62120 | REPAIR SKULL CAVITY LESION | Submit history and physical, documentation of medical necessity including operative report. |
| 62263 | EPIDURAL LYSIS MULT SESSIONS | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 62264 | EPIDURAL LYSIS ON SINGLE DAY | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 62280 | TREAT SPINAL CORD LESION | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 62281 | TREAT SPINAL CORD LESION | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 62282 | TREAT SPINAL CANAL LESION | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 62287 | PERCUTANEOUS DISKECTOMY | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 62292 | NJX CHEMONUCLEOLYSIS LMBR | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 62320 | NJX INTERLAMINAR CRV/THRC | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 62321 | NJX INTERLAMINAR CRV/THRC | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 62322 | NJX INTERLAMINAR LMBR/SAC | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 62323 | NJX INTERLAMINAR LMBR/SAC | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 62324 | NJX INTERLAMINAR CRV/THRC | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 62325 | NJX INTERLAMINAR CRV/THRC | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 62326 | NJX INTERLAMINAR LMBR/SAC | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |

| CPT and HCPCS Codes That May Require Prior Authorization | Description of Procedure Code | Medical Records Request Information Required |
|--|-------------------------------|---|
| 62327 | NJX INTERLAMINAR LMBR/SAC | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 62350 | IMPLANT SPINAL CANAL CATH | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 62351 | IMPLANT SPINAL CANAL CATH | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 62360 | INSERT SPINE INFUSION DEVICE | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 62361 | IMPLANT SPINE INFUSION PUMP | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 62362 | IMPLANT SPINE INFUSION PUMP | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 62380 | NDSC DCMPRN 1 NTRSPC LUMBAR | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 63001 | REMOVE SPINE LAMINA 1/2 CRVL | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 63005 | REMOVE SPINE LAMINA 1/2 LMBR | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 63012 | REMOVE LAMINA/FACETS LUMBAR | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 63015 | REMOVE SPINE LAMINA >2 CRVCL | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 63017 | REMOVE SPINE LAMINA >2 LMBR | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 63020 | NECK SPINE DISK SURGERY | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 63030 | LOW BACK DISK SURGERY | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 63035 | SPINAL DISK SURGERY ADD-ON | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 63040 | LAMINOTOMY SINGLE CERVICAL | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 63042 | LAMINOTOMY SINGLE LUMBAR | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 63043 | LAMINOTOMY ADDL CERVICAL | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 63044 | LAMINOTOMY ADDL LUMBAR | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 63045 | REMOVE SPINE LAMINA 1 CRVL | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 63047 | REMOVE SPINE LAMINA 1 LMBR | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 63048 | REMOVE SPINAL LAMINA ADD-ON | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |

| CPT and HCPCS Codes That May Require Prior Authorization | Description of Procedure Code | Medical Records Request Information Required |
|--|-------------------------------|---|
| 63050 | CERVICAL LAMINOPLSTY 2/> SEG | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 63051 | C-LAMINOPLASTY W/GRAFT/PLATE | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 63056 | DECOMPRESS SPINAL CORD LMBR | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 63057 | DECOMPRESS SPINE CORD ADD-ON | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 63075 | NECK SPINE DISK SURGERY | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 63076 | NECK SPINE DISK SURGERY | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 63081 | REMOVE VERT BODY DCMPRN CRVL | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 63082 | REMOVE VERTEBRAL BODY ADD-ON | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 63650 | IMPLANT NEUROELECTRODES | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 63655 | IMPLANT NEUROELECTRODES | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 63685 | INSRT/REDO SPINE N GENERATOR | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 63688 | REVISE/REMOVE NEURORECEIVER | submit history and physical, documentation of medical necessity. |
| 64400 | N BLOCK INJ TRIGEMINAL | Submit history and physical, documentation of medical necessity including operative report. |
| 64402 | N BLOCK INJ FACIAL | Submit history and physical, documentation of medical necessity including operative report. |
| 64405 | N BLOCK INJ OCCIPITAL | Submit history and physical, documentation of medical necessity including operative report. |
| 64408 | N BLOCK INJ VAGUS | Submit history and physical, documentation of medical necessity including operative report. |
| 64410 | N BLOCK INJ PHRENIC | Submit history and physical, documentation of medical necessity including operative report. |
| 64413 | N BLOCK INJ CERVICAL PLEXUS | Submit history and physical, documentation of medical necessity including operative report. |
| 64415 | N BLOCK INJ BRACHIAL PLEXUS | Submit history and physical, documentation of medical necessity including operative report. |
| 64416 | N BLOCK CONT INFUSE B PLEX | Submit history and physical, documentation of medical necessity including operative report. |
| 64417 | N BLOCK INJ AXILLARY | Submit history and physical, documentation of medical necessity including operative report. |
| 64418 | N BLOCK INJ SUPRASCAPULAR | Submit history and physical, documentation of medical necessity including operative report. |

| CPT and HCPCS Codes That May Require Prior Authorization | Description of Procedure Code | Medical Records Request Information Required |
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| 64420 | N BLOCK INJ INTERCOST SNG | Submit history and physical, documentation of medical necessity including operative report. |
| 64421 | N BLOCK INJ INTERCOST MLT | Submit history and physical, documentation of medical necessity including operative report. |
| 64425 | N BLOCK INJ ILIO-ING/HYPOGI | Submit history and physical, documentation of medical necessity including operative report. |
| 64430 | N BLOCK INJ PUDENDAL | Submit history and physical, documentation of medical necessity including operative report. |
| 64435 | N BLOCK INJ PARACERVICAL | Submit history and physical, documentation of medical necessity including operative report. |
| 64445 | N BLOCK INJ SCIATIC SNG | Submit history and physical, documentation of medical necessity including operative report. |
| 64446 | N BLK INJ SCIATIC CONT INF | Submit history and physical, documentation of medical necessity including operative report. |
| 64447 | N BLOCK INJ FEM SINGLE | Submit history and physical, documentation of medical necessity including operative report. |
| 64448 | N BLOCK INJ FEM CONT INF | Submit history and physical, documentation of medical necessity including operative report. |
| 64449 | N BLOCK INJ LUMBAR PLEXUS | Submit history and physical, documentation of medical necessity including operative report. |
| 64450 | N BLOCK OTHER PERIPHERAL | Submit history and physical, documentation of medical necessity including operative report. |
| 64451 | NJX AA&/STRD NRV NRVTG SI JT | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 64455 | N BLOCK INJ PLANTAR DIGIT | Submit history and physical, documentation of medical necessity including operative report. |
| 64479 | INJ FORAMEN EPIDURAL C/T | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 64480 | INJ FORAMEN EPIDURAL ADD-ON | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 64483 | INJ FORAMEN EPIDURAL L/S | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 64484 | INJ FORAMEN EPIDURAL ADD-ON | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 64490 | INJ PARAVERT F JNT C/T 1 LEV | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 64491 | INJ PARAVERT F JNT C/T 2 LEV | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 64492 | INJ PARAVERT F JNT C/T 3 LEV | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 64493 | INJ PARAVERT F JNT L/S 1 LEV | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 64494 | INJ PARAVERT F JNT L/S 2 LEV | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |

| CPT and HCPCS Codes That May Require Prior Authorization | Description of Procedure Code | Medical Records Request Information Required |
|--|--------------------------------------|---|
| 64495 | INJ PARAVERT F JNT L/S 3 LEV | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 64505 | N BLOCK SPENOPALATINE GANGL | Submit history and physical, documentation of medical necessity including operative report. |
| 64508 | AMA short description not available. | Submit history and physical, documentation of medical necessity including operative report. |
| 64510 | N BLOCK STELLATE GANGLION | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 64517 | N BLOCK INJ HYOGAS PLXS | Submit history and physical, documentation of medical necessity including operative report. |
| 64520 | N BLOCK LUMBAR/THORACIC | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 64530 | N BLOCK INJ CELIAC PELUS | Submit history and physical, documentation of medical necessity including operative report. |
| 64561 | IMPLANT NEUROELECTRODES | Submit History and Physical, documentation of medical necessity including operative report. |
| 64625 | RF ABLTJ NRV NRVTG SI JT | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 64633 | DESTROY CERV/THOR FACET JNT | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 64634 | DESTROY C/TH FACET JNT ADDL | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 64635 | DESTROY LUMB/SAC FACET JNT | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 64636 | DESTROY L/S FACET JNT ADDL | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 64721 | CARPAL TUNNEL SURGERY | Submit history and physical, documentation of medical necessity including operative report. |
| 64999 | NERVOUS SYSTEM SURGERY | Submit documentation to describe the services. Include history and physical with operative report or procedure report. |
| 65710 | CORNEAL TRANSPLANT | Pre-operative evaluation, history and physical and operative report. |
| 65730 | CORNEAL TRANSPLANT | Pre-operative evaluation, history and physical and operative report. |
| 65750 | CORNEAL TRANSPLANT | Pre-operative evaluation, history and physical and operative report. |
| 65755 | CORNEAL TRANSPLANT | Pre-operative evaluation, history and physical and operative report. |
| 65756 | CORNEAL TRNSPL ENDOTHELIAL | Pre-operative evaluation, history and physical and operative report. |
| 65757 | PREP CORNEAL ENDO ALLOGRAFT | Pre-operative evaluation, history and physical and operative report. |

| CPT and HCPCS Codes That May Require Prior Authorization | Description of Procedure Code | Medical Records Request Information Required |
|--|-------------------------------|---|
| 65767 | CORNEAL TISSUE TRANSPLANT | Pre-operative evaluation, history and physical and operative report. |
| 65780 | OCULAR RECONST TRANSPLANT | Pre-operative evaluation, history and physical and operative report. |
| 67900 | REPAIR BROW DEFECT | Pre Operative Evaluation, History and Physical and Operative report |
| 67901 | REPAIR EYELID DEFECT | Letter of medical necessity, including condition being treated. |
| 67902 | REPAIR EYELID DEFECT | Letter of medical necessity, including condition being treated. |
| 67903 | REPAIR EYELID DEFECT | Letter of medical necessity, including condition being treated. |
| 67904 | REPAIR EYELID DEFECT | Letter of medical necessity, including condition being treated. |
| 67906 | REPAIR EYELID DEFECT | Letter of medical necessity, including condition being treated. |
| 67908 | REPAIR EYELID DEFECT | Letter of medical necessity, including condition being treated. |
| 69300 | REVISE EXTERNAL EAR | Letter of medical necessity, including condition being treated. |
| 69604 | MASTOID SURGERY REVISION | Pre-operative evaluation, history and physical and operative report. |
| 69714 | IMPLANT TEMPLE BONE W/STIMUL | Pre-operative evaluation, history and physical and operative report. |
| 69715 | TEMPLE BNE IMPLNT W/STIMULAT | Pre-operative evaluation, operative eport, previous use of hearing aids, level of hearing Impairment. |
| 69717 | TEMPLE BONE IMPLANT REVISION | Pre-operative evaluation, operative eport, previous use of hearing aids, level of hearing Impairment. |
| 69718 | REVISE TEMPLE BONE IMPLANT | Pre-operative evaluation, operative eport, previous use of hearing aids, level of hearing Impairment. |
| 69930 | IMPLANT COCHLEAR DEVICE | Pre-operative evaluation, operative eport, previous use of hearing aids, level of hearing Impairment. |
| 70336 | MAGNETIC IMAGE JAW JOINT | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 70450 | CT HEAD/BRAIN W/O DYE | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 70460 | CT HEAD/BRAIN W/DYE | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 70470 | CT HEAD/BRAIN W/O & W/DYE | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 70480 | CT ORBIT/EAR/FOSSA W/O DYE | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 70481 | CT ORBIT/EAR/FOSSA W/DYE | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |

| CPT and HCPCS Codes That May Require Prior Authorization | Description of Procedure Code | Medical Records Request Information Required |
|--|-------------------------------|---|
| 70482 | CT ORBIT/EAR/FOSSA W/O&W/DYE | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 70486 | CT MAXILLOFACIAL W/O DYE | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 70487 | CT MAXILLOFACIAL W/DYE | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 70488 | CT MAXILLOFACIAL W/O & W/DYE | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 70490 | CT SOFT TISSUE NECK W/O DYE | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 70491 | CT SOFT TISSUE NECK W/DYE | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 70492 | CT SFT TSUE NCK W/O & W/DYE | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 70496 | CT ANGIOGRAPHY HEAD | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 70498 | CT ANGIOGRAPHY NECK | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 70540 | MRI ORBIT/FACE/NECK W/O DYE | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 70542 | MRI ORBIT/FACE/NECK W/DYE | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 70543 | MRI ORBT/FAC/NCK W/O &W/DYE | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 70544 | MR ANGIOGRAPHY HEAD W/O DYE | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 70545 | MR ANGIOGRAPHY HEAD W/DYE | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 70546 | MR ANGIOGRAPH HEAD W/O&W/DYE | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 70547 | MR ANGIOGRAPHY NECK W/O DYE | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 70548 | MR ANGIOGRAPHY NECK W/DYE | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 70549 | MR ANGIOGRAPH NECK W/O&W/DYE | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 70551 | MRI BRAIN STEM W/O DYE | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 70552 | MRI BRAIN STEM W/DYE | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 70553 | MRI BRAIN STEM W/O & W/DYE | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 70554 | FMRI BRAIN BY TECH | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |

| CPT and HCPCS Codes That May Require Prior Authorization | Description of Procedure Code | Medical Records Request Information Required |
|--|-------------------------------|---|
| 70555 | FMRI BRAIN BY PHYS/PSYCH | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 70557 | MRI BRAIN W/O DYE | For Prior Authorization: history and physical, results of previous diagnostics procedure report. |
| 70558 | MRI BRAIN W/DYE | For Prior Authorization: history and physical, results of previous diagnostics procedure report. |
| 70559 | MRI BRAIN W/O & W/DYE | For Prior Authorization: history and physical, results of previous diagnostics procedure report. |
| 71250 | CT THORAX W/O DYE | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 71260 | CT THORAX W/DYE | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 71270 | CT THORAX W/O & W/DYE | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 71271 | | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 71275 | CT ANGIOGRAPHY CHEST | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 71550 | MRI CHEST W/O DYE | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 71551 | MRI CHEST W/DYE | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 71552 | MRI CHEST W/O & W/DYE | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 71555 | MRI ANGIO CHEST W OR W/O DYE | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 72125 | CT NECK SPINE W/O DYE | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 72126 | CT NECK SPINE W/DYE | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 72127 | CT NECK SPINE W/O & W/DYE | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 72128 | CT CHEST SPINE W/O DYE | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 72129 | CT CHEST SPINE W/DYE | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 72130 | CT CHEST SPINE W/O & W/DYE | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 72131 | CT LUMBAR SPINE W/O DYE | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 72132 | CT LUMBAR SPINE W/DYE | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 72133 | CT LUMBAR SPINE W/O & W/DYE | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |

| CPT and HCPCS Codes That May Require Prior Authorization | Description of Procedure Code | Medical Records Request Information Required |
|--|-------------------------------|---|
| 72141 | MRI NECK SPINE W/O DYE | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 72142 | MRI NECK SPINE W/DYE | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 72146 | MRI CHEST SPINE W/O DYE | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 72147 | MRI CHEST SPINE W/DYE | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 72148 | MRI LUMBAR SPINE W/O DYE | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 72149 | MRI LUMBAR SPINE W/DYE | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 72156 | MRI NECK SPINE W/O & W/DYE | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 72157 | MRI CHEST SPINE W/O & W/DYE | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 72158 | MRI LUMBAR SPINE W/O & W/DYE | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 72159 | MR ANGIO SPINE W/O&W/DYE | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 72191 | CT ANGIOGRAPH PELV W/O&W/DYE | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 72192 | CT PELVIS W/O DYE | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 72193 | CT PELVIS W/DYE | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 72194 | CT PELVIS W/O & W/DYE | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 72195 | MRI PELVIS W/O DYE | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 72196 | MRI PELVIS W/DYE | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 72197 | MRI PELVIS W/O & W/DYE | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 72198 | MR ANGIO PELVIS W/O & W/DYE | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 73200 | CT UPPER EXTREMITY W/O DYE | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 73201 | CT UPPER EXTREMITY W/DYE | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 73202 | CT UPPR EXTREMITY W/O&W/DYE | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 73206 | CT ANGIO UPR EXTRM W/O&W/DYE | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |

| CPT and HCPCS Codes That May Require Prior Authorization | Description of Procedure Code | Medical Records Request Information Required |
|--|-------------------------------|---|
| 73218 | MRI UPPER EXTREMITY W/O DYE | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 73219 | MRI UPPER EXTREMITY W/DYE | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 73220 | MRI UPPR EXTREMITY W/O&W/DYE | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 73221 | MRI JOINT UPR EXTREM W/O DYE | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 73222 | MRI JOINT UPR EXTREM W/DYE | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 73223 | MRI JOINT UPR EXTR W/O&W/DYE | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 73225 | MR ANGIO UPR EXTR W/O&W/DYE | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 73700 | CT LOWER EXTREMITY W/O DYE | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 73701 | CT LOWER EXTREMITY W/DYE | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 73702 | CT LWR EXTREMITY W/O&W/DYE | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 73706 | CT ANGIO LWR EXTR W/O&W/DYE | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 73718 | MRI LOWER EXTREMITY W/O DYE | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 73719 | MRI LOWER EXTREMITY W/DYE | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 73720 | MRI LWR EXTREMITY W/O&W/DYE | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 73721 | MRI JNT OF LWR EXTRE W/O DYE | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 73722 | MRI JOINT OF LWR EXTR W/DYE | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 73723 | MRI JOINT LWR EXTR W/O&W/DYE | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 73725 | MR ANG LWR EXT W OR W/O DYE | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 74150 | CT ABDOMEN W/O DYE | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 74160 | CT ABDOMEN W/DYE | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 74170 | CT ABDOMEN W/O & W/DYE | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 74174 | CT ANGIO ABD&PELV W/O&W/DYE | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |

| CPT and HCPCS Codes That May Require Prior Authorization | Description of Procedure Code | Medical Records Request Information Required |
|--|-------------------------------|---|
| 74175 | CT ANGIO ABDOM W/O & W/DYE | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 74176 | CT ABD & PELVIS W/O CONTRAST | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 74177 | CT ABD & PELV W/CONTRAST | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 74178 | CT ABD & PELV 1/> REGNS | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 74181 | MRI ABDOMEN W/O DYE | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 74182 | MRI ABDOMEN W/DYE | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 74183 | MRI ABDOMEN W/O & W/DYE | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 74185 | MRI ANGIO ABDOM W ORW/O DYE | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 74261 | CT COLONOGRAPHY DX | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 74262 | CT COLONOGRAPHY DX W/DYE | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 74263 | CT COLONOGRAPHY SCREENING | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 74712 | MRI FETAL SNGL/1ST GESTATION | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 74713 | MRI FETAL EA ADDL GESTATION | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 75635 | CT ANGIO ABDOMINAL ARTERIES | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 76376 | 3D RENDER W/INTRP POSTPROCES | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 76377 | 3D RENDER W/INTRP POSTPROCES | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 76380 | CAT SCAN FOLLOW-UP STUDY | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 76390 | MR SPECTROSCOPY | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 76391 | MR ELASTOGRAPHY | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 76497 | CT PROCEDURE | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 76498 | MRI PROCEDURE | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 76506 | ECHO EXAM OF HEAD | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |

| CPT and HCPCS Codes That May Require Prior Authorization | Description of Procedure Code | Medical Records Request Information Required |
|--|-------------------------------|---|
| 76536 | US EXAM OF HEAD AND NECK | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 76604 | US EXAM CHEST | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 76641 | ULTRASOUND BREAST COMPLETE | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 76642 | ULTRASOUND BREAST LIMITED | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 76700 | US EXAM ABDOM COMPLETE | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 76705 | ECHO EXAM OF ABDOMEN | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 76706 | US ABDL AORTA SCREEN AAA | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 76770 | US EXAM ABDO BACK WALL COMP | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 76775 | US EXAM ABDO BACK WALL LIM | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 76776 | US EXAM K TRANSPL W/DOPPLER | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 76800 | US EXAM SPINAL CANAL | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 76801 | OB US < 14 WKS SINGLE FETUS | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 76802 | OB US < 14 WKS ADDL FETUS | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 76805 | OB US >= 14 WKS SNGL FETUS | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 76810 | OB US >= 14 WKS ADDL FETUS | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 76811 | OB US DETAILED SNGL FETUS | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 76812 | OB US DETAILED ADDL FETUS | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 76813 | OB US NUCHAL MEAS 1 GEST | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 76814 | OB US NUCHAL MEAS ADD-ON | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 76815 | OB US LIMITED FETUS(S) | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 76816 | OB US FOLLOW-UP PER FETUS | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 76817 | TRANSVAGINAL US OBSTETRIC | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |

| CPT and HCPCS Codes That May Require Prior Authorization | Description of Procedure Code | Medical Records Request Information Required |
|--|-------------------------------|---|
| 76818 | FETAL BIOPHYS PROFILE W/NST | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 76819 | FETAL BIOPHYS PROFIL W/O NST | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 76820 | UMBILICAL ARTERY ECHO | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 76821 | MIDDLE CEREBRAL ARTERY ECHO | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 76825 | ECHO EXAM OF FETAL HEART | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 76826 | ECHO EXAM OF FETAL HEART | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 76827 | ECHO EXAM OF FETAL HEART | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 76828 | ECHO EXAM OF FETAL HEART | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 76830 | TRANSVAGINAL US NON-OB | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 76831 | ECHO EXAM UTERUS | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 76856 | US EXAM PELVIC COMPLETE | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 76857 | US EXAM PELVIC LIMITED | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 76870 | US EXAM SCROTUM | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 76872 | US TRANSRECTAL | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 76881 | US COMPL JOINT R-T W/IMG | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 76882 | US LMTD JT/NONVASC XTR STRUX | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 76885 | US EXAM INFANT HIPS DYNAMIC | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 76886 | US EXAM INFANT HIPS STATIC | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 76965 | ECHO GUIDANCE RADIOTHERAPY | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 76975 | GI ENDOSCOPIC ULTRASOUND | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 76978 | US TRGT DYN MBUBB 1ST LES | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 76979 | US TRGT DYN MBUBB EA ADDL | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |

| CPT and HCPCS Codes That May Require Prior Authorization | Description of Procedure Code | Medical Records Request Information Required |
|--|-------------------------------|--|
| 77014 | CT SCAN FOR THERAPY GUIDE | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 77021 | MRI GUIDANCE NDL PLMT RS&I | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 77022 | MRI GDN PARNCHYMA TISS ABLTJ | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 77046 | MRI BREAST C- UNILATERAL | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 77047 | MRI BREAST C- BILATERAL | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 77048 | MRI BREAST C++ W/CAD UNI | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 77049 | MRI BREAST C++ W/CAD BI | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 77078 | CT BONE DENSITY AXIAL | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 77084 | MAGNETIC IMAGE BONE MARROW | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 77371 | SRS MULTISOURCE | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 77372 | SRS LINEAR BASED | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 77373 | SBRT DELIVERY | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 77385 | NTSTY MODUL RAD TX DLVR SMPL | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 77386 | NTSTY MODUL RAD TX DLVR CPLX | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 77387 | GUIDANCE FOR RADJ TX DLVR | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 77401 | RADIATION TREATMENT DELIVERY | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 77402 | RADIATION TREATMENT DELIVERY | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 77407 | RADIATION TREATMENT DELIVERY | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 77412 | RADIATION TREATMENT DELIVERY | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 77423 | NEUTRON BEAM TX COMPLEX | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 77424 | IO RAD TX DELIVERY BY X-RAY | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 77425 | IO RAD TX DELIVER BY ELCTRNS | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |

| CPT and HCPCS Codes That May Require Prior Authorization | Description of Procedure Code | Medical Records Request Information Required |
|--|-------------------------------|---|
| 77520 | PROTON TRMT SIMPLE W/O COMP | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 77522 | PROTON TRMT SIMPLE W/COMP | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 77523 | PROTON TRMT INTERMEDIATE | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 77525 | PROTON TREATMENT COMPLEX | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 77600 | HYPERTHERMIA TREATMENT | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 77605 | HYPERTHERMIA TREATMENT | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 77610 | HYPERTHERMIA TREATMENT | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 77615 | HYPERTHERMIA TREATMENT | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 77620 | HYPERTHERMIA TREATMENT | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 77750 | INFUSE RADIOACTIVE MATERIALS | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 77761 | APPLY INTRCAV RADIAT SIMPLE | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 77762 | APPLY INTRCAV RADIAT INTERM | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 77763 | APPLY INTRCAV RADIAT COMPL | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 77767 | HDR RDNCL SKN SURF BRACHYTX | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 77768 | HDR RDNCL SKN SURF BRACHYTX | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 77770 | HDR RDNCL NTRSTL/ICAV BRCHTX | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 77771 | HDR RDNCL NTRSTL/ICAV BRCHTX | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 77772 | HDR RDNCL NTRSTL/ICAV BRCHTX | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 77778 | APPLY INTERSTIT RADIAT COMPL | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 78012 | THYROID UPTAKE MEASUREMENT | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 78013 | THYROID IMAGING W/BLOOD FLOW | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 78014 | THYROID IMAGING W/BLOOD FLOW | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |

| CPT and HCPCS Codes That May Require Prior Authorization | Description of Procedure Code | Medical Records Request Information Required |
|--|-------------------------------|---|
| 78015 | THYROID MET IMAGING | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 78016 | THYROID MET IMAGING/STUDIES | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 78018 | THYROID MET IMAGING BODY | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 78020 | THYROID MET UPTAKE | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 78070 | PARATHYROID PLANAR IMAGING | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 78071 | PARATHYRD PLANAR W/WO SUBTRJ | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 78072 | PARATHYRD PLANAR W/SPECT&CT | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 78075 | ADRENAL CORTEX & MEDULLA IMG | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 78102 | BONE MARROW IMAGING LTD | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 78103 | BONE MARROW IMAGING MULT | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 78104 | BONE MARROW IMAGING BODY | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 78185 | SPLEEN IMAGING | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 78195 | LYMPH SYSTEM IMAGING | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 78201 | LIVER IMAGING | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 78202 | LIVER IMAGING WITH FLOW | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 78215 | LIVER AND SPLEEN IMAGING | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 78216 | LIVER & SPLEEN IMAGE/FLOW | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 78226 | HEPATOBIILIARY SYSTEM IMAGING | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 78227 | HEPATOBIL SYST IMAGE W/DRUG | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 78230 | SALIVARY GLAND IMAGING | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 78231 | SERIAL SALIVARY IMAGING | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 78232 | SALIVARY GLAND FUNCTION EXAM | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |

| CPT and HCPCS Codes That May Require Prior Authorization | Description of Procedure Code | Medical Records Request Information Required |
|--|-------------------------------|---|
| 78258 | ESOPHAGEAL MOTILITY STUDY | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 78261 | GASTRIC MUCOSA IMAGING | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 78262 | GASTROESOPHAGEAL REFLUX EXAM | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 78264 | GASTRIC EMPTYING IMAG STUDY | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 78265 | GASTRIC EMPTYING IMAG STUDY | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 78266 | GASTRIC EMPTYING IMAG STUDY | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 78278 | ACUTE GI BLOOD LOSS IMAGING | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 78290 | MECKELS DIVERT EXAM | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 78291 | LEVEEN/SHUNT PATENCY EXAM | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 78300 | BONE IMAGING LIMITED AREA | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 78305 | BONE IMAGING MULTIPLE AREAS | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 78306 | BONE IMAGING WHOLE BODY | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 78315 | BONE IMAGING 3 PHASE | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 78445 | VASCULAR FLOW IMAGING | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 78456 | ACUTE VENOUS THROMBUS IMAGE | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 78457 | VENOUS THROMBOSIS IMAGING | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 78458 | VEN THROMBOSIS IMAGES BILAT | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 78579 | LUNG VENTILATION IMAGING | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 78580 | LUNG PERFUSION IMAGING | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 78582 | LUNG VENTILAT&PERFUS IMAGING | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 78597 | LUNG PERFUSION DIFFERENTIAL | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 78598 | LUNG PERF&VENTILAT DIFERENTL | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |

| CPT and HCPCS Codes That May Require Prior Authorization | Description of Procedure Code | Medical Records Request Information Required |
|--|-------------------------------|--|
| 78600 | BRAIN IMAGE < 4 VIEWS | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 78601 | BRAIN IMAGE W/FLOW < 4 VIEWS | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 78605 | BRAIN IMAGE 4+ VIEWS | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 78606 | BRAIN IMAGE W/FLOW 4 + VIEWS | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 78608 | BRAIN IMAGING (PET) | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 78609 | BRAIN IMAGING (PET) | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 78610 | BRAIN FLOW IMAGING ONLY | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 78630 | CEREBROSPINAL FLUID SCAN | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 78635 | CSF VENTRICULOGRAPHY | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 78645 | CSF SHUNT EVALUATION | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 78650 | CSF LEAKAGE IMAGING | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 78660 | NUCLEAR EXAM OF TEAR FLOW | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 78700 | KIDNEY IMAGING MORPHOL | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 78701 | KIDNEY IMAGING WITH FLOW | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 78707 | K FLOW/FUNCT IMAGE W/O DRUG | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 78708 | K FLOW/FUNCT IMAGE W/DRUG | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 78709 | K FLOW/FUNCT IMAGE MULTIPLE | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 78725 | KIDNEY FUNCTION STUDY | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 78730 | URINARY BLADDER RETENTION | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 78740 | URETERAL REFLUX STUDY | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 78761 | TESTICULAR IMAGING W/FLOW | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 78800 | TUMOR IMAGING LIMITED AREA | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |

| CPT and HCPCS Codes That May Require Prior Authorization | Description of Procedure Code | Medical Records Request Information Required |
|--|-------------------------------|---|
| 78801 | TUMOR IMAGING MULT AREAS | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 78802 | TUMOR IMAGING WHOLE BODY | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 78803 | TUMOR IMAGING (3D) | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 78804 | TUMOR IMAGING WHOLE BODY | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 78811 | PET IMAGE LTD AREA | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 78812 | PET IMAGE SKULL-THIGH | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 78813 | PET IMAGE FULL BODY | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 78814 | PET IMAGE W/CT LMTD | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 78815 | PET IMAGE W/CT SKULL-THIGH | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 78816 | PET IMAGE W/CT FULL BODY | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 78830 | RP LOCLZJ TUM SPECT W/CT 1 | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 78831 | RP LOCLZJ TUM SPECT 2 AREAS | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 78832 | RP LOCLZJ TUM SPECT W/CT 2 | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 78999 | NUCLEAR DIAGNOSTIC EXAM | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 79005 | NUCLEAR RX ORAL ADMIN | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 79101 | NUCLEAR RX IV ADMIN | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 79403 | HEMATOPOIETIC NUCLEAR TX | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 81162 | BRCA1&2 GEN FULL SEQ DUP/DEL | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 81163 | BRCA1&2 GEN FULL SEQ DUP/DEL | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 81164 | BRCA1&2 GEN FULL SEQ DUP/DEL | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 81165 | BRCA1&2 GEN FULL SEQ DUP/DEL | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 81166 | BRCA1&2 GEN FULL SEQ DUP/DEL | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |

| CPT and HCPCS Codes That May Require Prior Authorization | Description of Procedure Code | Medical Records Request Information Required |
|--|-------------------------------|--|
| 81167 | BRCA1&2 GEN FULL SEQ DUP/DEL | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 81173 | AR GENE FULL GENE SEQUENCE | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 81174 | AR GENE KNOWN FAMIL VARIANT | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 81185 | CACNA1A GENE FULL GENE SEQ | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 81186 | CACNA1A GEN KNOWN FAMIL VRNT | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 81189 | CSTB GENE FULL GENE SEQUENCE | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 81190 | CSTB GENE KNOWN FAMIL VRNT | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 81201 | APC GENE FULL SEQUENCE | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 81202 | APC GENE KNOWN FAM VARIANTS | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 81203 | APC GENE DUP/DELET VARIANTS | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 81212 | BRCA1&2 185&5385&6174 VRNT | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 81215 | BRCA1 GENE KNOWN FAMIL VRNT | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 81216 | BRCA2 GENE FULL SEQ ALYS | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 81217 | BRCA2 GENE KNOWN FAMIL VRNT | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 81221 | CFTR GENE KNOWN FAM VARIANTS | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 81222 | CFTR GENE DUP/DELET VARIANTS | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 81223 | CFTR GENE FULL SEQUENCE | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 81225 | CYP2C19 GENE COM VARIANTS | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 81226 | CYP2D6 GENE COM VARIANTS | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 81227 | CYP2C9 GENE COM VARIANTS | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 81228 | CYTOGEN MICRARRAY COPY NMBR | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 81229 | CYTOGEN M ARRAY COPY NO&SNP | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |

| CPT and HCPCS Codes That May Require Prior Authorization | Description of Procedure Code | Medical Records Request Information Required |
|--|---|---|
| 81230 | CYP3A4 GENE COMMON VARIANTS | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 81231 | CYP3A5 GENE COMMON VARIANTS | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 81232 | DPYD GENE COMMON VARIANTS | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 81238 | F9 FULL GENE SEQUENCE | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 81248 | G6PD KNOWN FAMILIAL VARIANT | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 81249 | G6PD FULL GENE SEQUENCE | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 81252 | GJB2 GENE FULL SEQUENCE | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 81253 | GJB2 GENE KNOWN FAM VARIANTS | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 81257 | HBA1/HBA2 GENE | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 81258 | HBA1/HBA2 GENE FAM VRNT | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 81259 | HBA1/HBA2 FULL GENE SEQUENCE | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 81269 | HBA1/HBA2 GENE DUP/DEL VRNTS | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 81277 | CYTOGENOMIC NEO MICRORA ALYS | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 81278 | Short description not available at time of distribution | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 81279 | Short description not available at time of distribution | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 81283 | IFNL3 GENE | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 81286 | FXN GENE FULL GENE SEQUENCE | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 81289 | FXN GENE KNOWN FAMIL VARIANT | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 81291 | MTHFR GENE | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 81292 | MLH1 GENE FULL SEQ | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 81293 | MLH1 GENE KNOWN VARIANTS | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 81294 | MLH1 GENE DUP/DELETE VARIANT | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |

| CPT and HCPCS Codes That May Require Prior Authorization | Description of Procedure Code | Medical Records Request Information Required |
|--|-------------------------------|---|
| 81295 | MSH2 GENE FULL SEQ | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 81296 | MSH2 GENE KNOWN VARIANTS | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 81297 | MSH2 GENE DUP/DELETE VARIANT | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 81298 | MSH6 GENE FULL SEQ | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 81299 | MSH6 GENE KNOWN VARIANTS | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 81300 | MSH6 GENE DUP/DELETE VARIANT | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 81302 | MECP2 GENE FULL SEQ | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 81303 | MECP2 GENE KNOWN VARIANT | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 81304 | MECP2 GENE DUP/DELET VARIANT | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 81306 | NUDT15 GENE COMMON VARIANTS | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 81307 | PALB2 GENE FULL GENE SEQ | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 81308 | PALB2 GENE KNOWN FAMIL VRNT | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 81313 | PCA3/KLK3 ANTIGEN | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 81317 | PMS2 GENE FULL SEQ ANALYSIS | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 81318 | PMS2 KNOWN FAMILIAL VARIANTS | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 81319 | PMS2 GENE DUP/DELET VARIANTS | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 81321 | PTEN GENE FULL SEQUENCE | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 81322 | PTEN GENE KNOWN FAM VARIANT | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 81323 | PTEN GENE DUP/DELET VARIANT | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 81325 | PMP22 GENE FULL SEQUENCE | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 81326 | PMP22 GENE KNOWN FAM VARIANT | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 81327 | SEPT9 GEN PRMTR MTHYLTN ALYS | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |

| CPT and HCPCS Codes That May Require Prior Authorization | Description of Procedure Code | Medical Records Request Information Required |
|--|---|---|
| 81328 | SLCO1B1 GENE COM VARIANTS | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 81335 | TPMT GENE COM VARIANTS | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 81336 | SMN1 GENE FULL GENE SEQUENCE | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 81337 | SMN1 GEN NOWN FAMIL SEQ VRNT | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 81346 | TYMS GENE COM VARIANTS | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 81350 | UGT1A1 GENE | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 81351 | Short description not available at time of distribution | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 81353 | Short description not available at time of distribution | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 81355 | VKORC1 GENE | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 81361 | HBB GENE COM VARIANTS | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 81362 | HBB GENE KNOWN FAM VARIANT | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 81363 | HBB GENE DUP/DEL VARIANTS | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 81364 | HBB FULL GENE SEQUENCE | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 81400 | MOPATH PROCEDURE LEVEL 1 | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 81401 | MOPATH PROCEDURE LEVEL 2 | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 81402 | MOPATH PROCEDURE LEVEL 3 | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 81403 | MOPATH PROCEDURE LEVEL 4 | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 81404 | MOPATH PROCEDURE LEVEL 5 | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 81405 | MOPATH PROCEDURE LEVEL 6 | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 81406 | MOPATH PROCEDURE LEVEL 7 | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 81407 | MOPATH PROCEDURE LEVEL 8 | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 81408 | MOPATH PROCEDURE LEVEL 9 | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |

| CPT and HCPCS Codes That May Require Prior Authorization | Description of Procedure Code | Medical Records Request Information Required |
|--|---|---|
| 81410 | AORTIC DYSFUNCTION/DILATION | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 81411 | AORTIC DYSFUNCTION/DILATION | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 81412 | ASHKENAZI JEWISH ASSOC DIS | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 81413 | CAR ION CHNNLPATH INC 10 GNS | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 81414 | CAR ION CHNNLPATH INC 2 GNS | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 81415 | EXOME SEQUENCE ANALYSIS | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 81416 | EXOME SEQUENCE ANALYSIS | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 81417 | EXOME RE-EVALUATION | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 81419 | Short description not available at time of distribution | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 81422 | FETAL CHRMOML MICRODELTA | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 81425 | GENOME SEQUENCE ANALYSIS | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 81426 | GENOME SEQUENCE ANALYSIS | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 81427 | GENOME RE-EVALUATION | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 81430 | HEARING LOSS SEQUENCE ANALYSIS | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 81431 | HEARING LOSS DUP/DEL ANALYSIS | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 81432 | HRDTRY BRST CA-RLATD DSORDRS | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 81433 | HRDTRY BRST CA-RLATD DSORDRS | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 81434 | HEREDITARY RETINAL DISORDERS | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 81435 | HEREDITARY COLON CA DSORDRS | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 81436 | HEREDITARY COLON CA DSORDRS | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 81437 | HEREDTRY NURONDCRN TUM DSRDR | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 81438 | HEREDTRY NURONDCRN TUM DSRDR | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |

| CPT and HCPCS Codes That May Require Prior Authorization | Description of Procedure Code | Medical Records Request Information Required |
|--|-------------------------------|---|
| 81439 | HRDTRY CARDMYPY GENE PANEL | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 81440 | MITOCHONDRIAL GENE | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 81442 | NOONAN SPECTRUM DISORDERS | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 81443 | TARGETED GENOMIC SEQ ANALYS | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 81445 | TARGETED GENOMIC SEQ ANALYS | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 81448 | HRDTRY PERPH NEURPHY PANEL | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 81450 | TARGETED GENOMIC SEQ ANALYS | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 81455 | TARGETED GENOMIC SEQ ANALYS | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 81460 | WHOLE MITOCHONDRIAL GENOME | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 81465 | WHOLE MITOCHONDRIAL GENOME | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 81470 | X-LINKED INTELLECTUAL DBLT | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 81471 | X-LINKED INTELLECTUAL DBLT | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 81479 | UNLISTED MOLECULAR PATHOLOGY | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 81490 | AUTOIMMUNE RHEUMATOID ARTHR | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 81493 | COR ARTERY DISEASE MRNA | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 81500 | ONCO (OVAR) TWO PROTEINS | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 81503 | ONCO (OVAR) FIVE PROTEINS | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 81504 | ONCOLOGY TISSUE OF ORIGIN | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 81518 | ONCOLOGY BREAST MRNA | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 81519 | ONCOLOGY BREAST MRNA | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 81520 | ONC BREAST MRNA 58 GENES | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 81521 | ONC BREAST MRNA 70 GENES | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |

| CPT and HCPCS Codes That May Require Prior Authorization | Description of Procedure Code | Medical Records Request Information Required |
|--|---|---|
| 81522 | ONC BREAST MRNA 12 GENES | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 81525 | ONCOLOGY COLON MRNA | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 81529 | Short description not available at time of distribution | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 81535 | ONCOLOGY GYNECOLOGIC | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 81536 | ONCOLOGY GYNECOLOGIC | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 81538 | ONCOLOGY LUNG | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 81539 | ONCOLOGY PROSTATE PROB SCORE | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 81540 | ONCOLOGY TUM UNKNOWN ORIGIN | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 81541 | ONC PROSTATE MRNA 46 GENES | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 81542 | ONC PROSTATE MRNA 22 CNT GEN | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 81545 | ONCOLOGY THYROID | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 81546 | Short description not available at time of distribution | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 81551 | ONC PROSTATE 3 GENES | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 81552 | ONC UVEAL MLNMA MRNA 15 GENE | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 81554 | Short description not available at time of distribution | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 81595 | CARDIOLOGY HRT TRNSPL MRNA | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 81596 | NFCT DS CHRNC HCV 6 ASSAYS | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 81599 | UNLISTED MAAA | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 84999 | CLINICAL CHEMISTRY TEST | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 86890 | AUTOLOGOUS BLOOD PROCESS | Submit documentation to describe the test, records from related office visit, history and physical. |
| 86891 | AUTOLOGOUS BLOOD OP SALVAGE | Submit documentation to describe the test, records from related office visit, history and physical. |
| 89250 | CULTR OOCYTE/EMBRYO <4 DAYS | Submit documentation to describe the test, records from related office visit, history and physical. |

| CPT and HCPCS Codes That May Require Prior Authorization | Description of Procedure Code | Medical Records Request Information Required |
|--|-------------------------------|---|
| 89290 | BIOPSY OOCYTE POLAR BODY | Submit documentation to describe the test, records from related office visit, history and physical. |
| 89291 | BIOPSY OOCYTE POLAR BODY | Submit documentation to describe the test, records from related office visit, history and physical. |
| 90281 | HUMAN IG IM | For MMAI plans contact Prime Therapeutics, Fax 877-243-6930 or Call 800-285-9426, website MyPrime.com or CoverMyMeds.com |
| 90281 | HUMAN IG IM | For II Medicaid plans contact eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 90283 | HUMAN IG IV | For MMAI plans contact Prime Therapeutics, Fax 877-243-6930 or Call 800-285-9426, website MyPrime.com or CoverMyMeds.com |
| 90283 | HUMAN IG IV | For II Medicaid plans contact eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 90284 | HUMAN IG SC | For MMAI plans contact Prime Therapeutics, Fax 877-243-6930 or Call 800-285-9426, website MyPrime.com or CoverMyMeds.com |
| 90284 | HUMAN IG SC | For II Medicaid plans contact eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 90378 | RSV MAB IM 50MG | For MMAI plans contact Prime Therapeutics, Fax 877-243-6930 or Call 800-285-9426, website MyPrime.com or CoverMyMeds.com |
| 90378 | RSV MAB IM 50MG | For II Medicaid plans contact eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 90399 | IMMUNE GLOBULIN | History and physical, chart notes from ordering physician, treatment plan. |
| 90863 | PHARMACOLOGIC MGMT W/PSYTX | History and physical, chart notes from ordering physician, treatment plan. |
| 90870 | ELECTROCONVULSIVE THERAPY | History and physical, chart notes from ordering physician, treatment plan. |
| 90901 | BIOFEEDBACK TRAIN ANY METH | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 90999 | DIALYSIS PROCEDURE | History and physical, chart notes from ordering physician, treatment plan and results. |
| 91111 | ESOPHAGEAL CAPSULE ENDOSCOPY | Recent history and physical, plan of care, and documentation of medical necessity. |
| 92507 | SPEECH/HEARING THERAPY | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 92508 | SPEECH/HEARING THERAPY | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 92511 | NASOPHARYNGOSCOPY | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 92520 | LARYNGEAL FUNCTION STUDIES | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |

| CPT and HCPCS Codes That May Require Prior Authorization | Description of Procedure Code | Medical Records Request Information Required |
|--|-------------------------------|---|
| 92521 | EVALUATION OF SPEECH FLUENCY | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 92522 | EVALUATE SPEECH PRODUCTION | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 92523 | SPEECH SOUND LANG COMPREHEN | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 92524 | BEHAVRAL QUALIT ANALYS VOICE | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 92526 | ORAL FUNCTION THERAPY | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 92548 | POSTUROGRAPHY | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 92584 | ELECTROCOCHLEOGRAPHY | Recent history and physical, plan of care, and documentation of medical necessity. |
| 92597 | ORAL SPEECH DEVICE EVAL | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 92601 | COCHLEAR IMPLT F/UP EXAM <7 | Recent history and physical, plan of care, and documentation of medical necessity. |
| 92602 | REPROGRAM COCHLEAR IMPLT <7 | Recent history and physical, plan of care, and documentation of medical necessity. |
| 92603 | COCHLEAR IMPLT F/UP EXAM 7/> | Recent history and physical, plan of care, and documentation of medical necessity. |
| 92604 | REPROGRAM COCHLEAR IMPLT 7/> | Recent history and physical, plan of care, and documentation of medical necessity. |
| 92605 | EX FOR NONSPEECH DEVICE RX | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 92606 | NON-SPEECH DEVICE SERVICE | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 92607 | EX FOR SPEECH DEVICE RX 1HR | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 92608 | EX FOR SPEECH DEVICE RX ADDL | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 92609 | USE OF SPEECH DEVICE SERVICE | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 92610 | EVALUATE SWALLOWING FUNCTION | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 92611 | MOTION FLUOROSCOPY/SWALLOW | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 92612 | ENDOSCOPY SWALLOW (FEES) VID | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 92613 | ENDOSCOPY SWALLOW (FEES) I&R | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 92614 | LARYNGOSCOPIC SENSORY VID | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |

| CPT and HCPCS Codes That May Require Prior Authorization | Description of Procedure Code | Medical Records Request Information Required |
|--|-------------------------------|---|
| 92615 | LARYNGOSCOPIC SENSORY I&R | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 92616 | FEES W/LARYNGEAL SENSE TEST | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 92617 | FEES W/LARYNGEAL SENSE I&R | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 92618 | EX FOR NONSPEECH DEV RX ADD | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 92626 | EVAL AUD REHAB STATUS | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 92627 | EVAL AUD STATUS REHAB ADD-ON | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 92630 | AUD REHAB PRE-LING HEAR LOSS | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 92633 | AUD REHAB POSTLING HEAR LOSS | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 92928 | PRQ CARD STENT W/ANGIO 1 VSL | Letter of medical necessity, including condition being treated. |
| 93228 | REMOTE 30 DAY ECG REV/REPORT | Recent history and physical, plan of care, and documentation of medical necessity. |
| 93229 | REMOTE 30 DAY ECG TECH SUPP | Recent history and physical, plan of care, and documentation of medical necessity. |
| 93621 | ELECTROPHYSIOLOGY EVALUATION | Letter of medical necessity, including condition being treated. |
| 93653 | EP & ABLATE SUPRAVENT ARRHYT | Letter of medical necessity, including condition being treated. |
| 93656 | TX ATRIAL FIB PULM VEIN ISOL | Letter of medical necessity, including condition being treated. |
| 93880 | EXTRACRANIAL BILAT STUDY | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 93882 | EXTRACRANIAL UNI/LTD STUDY | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 93886 | INTRACRANIAL COMPLETE STUDY | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 93888 | INTRACRANIAL LIMITED STUDY | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 93890 | TCD VASOREACTIVITY STUDY | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 93892 | TCD EMBOLI DETECT W/O INJ | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 93893 | TCD EMBOLI DETECT W/INJ | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 93922 | UPR/L XTREMITY ART 2 LEVELS | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |

| CPT and HCPCS Codes That May Require Prior Authorization | Description of Procedure Code | Medical Records Request Information Required |
|--|---|---|
| 93923 | UPR/LXTR ART STDY 3+ LVLS | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 93924 | LWR XTR VASC STDY BILAT | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 93925 | LOWER EXTREMITY STUDY | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 93926 | LOWER EXTREMITY STUDY | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 93930 | UPPER EXTREMITY STUDY | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 93931 | UPPER EXTREMITY STUDY | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 93970 | EXTREMITY STUDY | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 93971 | EXTREMITY STUDY | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 93975 | VASCULAR STUDY | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 93976 | VASCULAR STUDY | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 93978 | VASCULAR STUDY | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 93979 | VASCULAR STUDY | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 93980 | PENILE VASCULAR STUDY | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 93981 | PENILE VASCULAR STUDY | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 93985 | Short Description not available at time of distribution | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 93986 | Short Description not available at time of distribution | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 93990 | DOPPLER FLOW TESTING | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 93998 | NONINVAS VASC DX STUDY PROC | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 94660 | POS AIRWAY PRESSURE CPAP | Recent history and physical, plan of care, and documentation of medical necessity. |
| 95782 | POLYSOM <6 YRS 4/> PARAMTRS | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 95783 | POLYSOM <6 YRS CPAP/BILVL | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 95800 | SLP STDY UNATTENDED | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |

| CPT and HCPCS Codes That May Require Prior Authorization | Description of Procedure Code | Medical Records Request Information Required |
|--|-------------------------------|---|
| 95801 | SLP STDY UNATND W/ANAL | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 95803 | ACTIGRAPHY TESTING | Recent history and physical, plan of care, and documentation of medical necessity. |
| 95805 | MULTIPLE SLEEP LATENCY TEST | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 95806 | SLEEP STUDY UNATT&RESP EFFT | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 95807 | SLEEP STUDY ATTENDED | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 95808 | POLYSOM ANY AGE 1-3> PARAM | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 95810 | POLYSOM 6/> YRS 4/> PARAM | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 95811 | POLYSOM 6/>YRS CPAP 4/> PARM | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 95851 | RANGE OF MOTION MEASUREMENTS | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 95852 | RANGE OF MOTION MEASUREMENTS | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 95992 | CANALITH REPOSITIONING PROC | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 96040 | GENETIC COUNSELING 30 MIN | Recent history and physical, plan of care, and documentation of medical necessity. |
| 96105 | ASSESSMENT OF APHASIA | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 96110 | DEVELOPMENTAL SCREEN W/SCORE | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 96112 | DEVEL TST PHYS/QHP 1ST HR | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 96113 | DEVEL TST PHYS/QHP EA ADDL | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 96125 | COGNITIVE TEST BY HC PRO | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 97010 | HOT OR COLD PACKS THERAPY | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 97012 | MECHANICAL TRACTION THERAPY | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 97014 | ELECTRIC STIMULATION THERAPY | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 97016 | VASOPNEUMATIC DEVICE THERAPY | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 97018 | PARAFFIN BATH THERAPY | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |

| CPT and HCPCS Codes That May Require Prior Authorization | Description of Procedure Code | Medical Records Request Information Required |
|--|-------------------------------|---|
| 97022 | WHIRLPOOL THERAPY | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 97024 | DIATHERMY EG MICROWAVE | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 97026 | INFRARED THERAPY | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 97028 | ULTRAVIOLET THERAPY | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 97032 | ELECTRICAL STIMULATION | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 97033 | ELECTRIC CURRENT THERAPY | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 97034 | CONTRAST BATH THERAPY | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 97035 | ULTRASOUND THERAPY | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 97036 | HYDROTHERAPY | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 97039 | PHYSICAL THERAPY TREATMENT | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 97110 | THERAPEUTIC EXERCISES | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 97112 | NEUROMUSCULAR REEDUCATION | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 97113 | AQUATIC THERAPY/EXERCISES | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 97116 | GAIT TRAINING THERAPY | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 97124 | MASSAGE THERAPY | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 97129 | THER IVNTJ 1ST 15 MIN | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 97130 | THER IVNTJ EA ADDL 15 MIN | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 97139 | PHYSICAL MEDICINE PROCEDURE | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 97140 | MANUAL THERAPY 1/> REGIONS | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 97150 | GROUP THERAPEUTIC PROCEDURES | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 97164 | PT RE-EVAL EST PLAN CARE | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 97165 | OT EVAL LOW COMPLEX 30 MIN | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |

| CPT and HCPCS Codes That May Require Prior Authorization | Description of Procedure Code | Medical Records Request Information Required |
|--|-------------------------------|---|
| 97166 | OT EVAL MOD COMPLEX 45 MIN | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 97167 | OT EVAL HIGH COMPLEX 60 MIN | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 97168 | OT RE-EVAL EST PLAN CARE | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 97530 | THERAPEUTIC ACTIVITIES | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 97533 | SENSORY INTEGRATION | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 97535 | SELF CARE MNGMENT TRAINING | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 97537 | COMMUNITY/WORK REINTEGRATION | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 97542 | WHEELCHAIR MNGMENT TRAINING | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 97545 | WORK HARDENING | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 97546 | WORK HARDENING ADD-ON | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 97597 | RMVL DEVITAL TIS 20 CM/< | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 97598 | RMVL DEVITAL TIS ADDL 20CM/< | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 97602 | WOUND(S) CARE NON-SELECTIVE | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 97605 | NEG PRESS WOUND TX </=50 CM | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 97606 | NEG PRESS WOUND TX >50 CM | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 97750 | PHYSICAL PERFORMANCE TEST | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 97755 | ASSISTIVE TECHNOLOGY ASSESS | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 97760 | ORTHOTIC MGMT&TRAINJ 1ST ENC | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 97761 | PROSTHETIC TRAINJ 1ST ENC | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 97763 | ORTHC/PROSTC MGMT SBSQ ENC | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 97799 | PHYSICAL MEDICINE PROCEDURE | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 97810 | ACUPUNCT W/O STIMUL 15 MIN | Recent history and physical, plan of care, and documentation of medical necessity. |

| CPT and HCPCS Codes That May Require Prior Authorization | Description of Procedure Code | Medical Records Request Information Required |
|--|---|---|
| 98940 | CHIROPRACT MANJ 1-2 REGIONS | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 98941 | CHIROPRACT MANJ 3-4 REGIONS | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 98942 | CHIROPRACTIC MANJ 5 REGIONS | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 98943 | CHIROPRACT MANJ XTRSPINL 1/> | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 99183 | HYPERBARIC OXYGEN THERAPY | Recent history and physical, plan of care, and documentation of medical necessity. |
| 99601 | HOME INFUSION/VISIT 2 HRS | Recent history and physical, plan of care, and documentation of medical necessity. |
| 99602 | HOME INFUSION EACH ADDTL HR | Recent history and physical, plan of care, and documentation of medical necessity. |
| 0001U | RBC DNA HEA 35 AG 11 BLD GRP | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 0002M | Liver disease | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 0003M | Liver disease | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 0004M | SCO 53 SNPS | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 0006U | SARS-CoV-2 | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 0006M | Onc hep gene risk classifier | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 0007M | Onc gastro 51 gene nomogram | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 0011M | ONC PRST8 CA MRNA 12 GEN ALG | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 0012M | ONC MRNA 5 GEN RSK URTHL CA | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 0012U | GERMLN DO GENE REARGMT DETCJ | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 0013M | ONC MRNA 5 GEN RECR URTHL CA | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 0013U | ONC SLD ORG NEO GENE REARGMT | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 0014U | HEM HMTLMF NEO GENE REARGMT | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 0016M | Short Description not available at time of distribution | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 0017M | SARS-CoV-2 | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |

| CPT and HCPCS Codes That May Require Prior Authorization | Description of Procedure Code | Medical Records Request Information Required |
|--|-------------------------------|---|
| 0018U | ONC THYR 10 MICRORNA SEQ ALG | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 0019T | EXTRACORP SHOCK WV TX,MS NOS | Recent history and physical, plan of care, and documentation of medical necessity. |
| 0019U | ONC RNA TISS PREDICT ALG | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 0022U | TRGT GEN SEQ DNA&RNA 23 GENE | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 0026U | ONC THYR DNA&MRNA 112 GENES | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 0029U | RX METAB ADVRS TRGT SEQ ALYS | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 0030U | RX METAB WARF TRGT SEQ ALYS | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 0031U | CYP1A2 GENE | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 0032U | COMT GENE | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 0033U | HTR2A HTR2C GENES | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 0034U | TPMT NUDT15 GENES | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 0036U | XOME TUM & NML SPEC SEQ ALYS | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 0037U | TRGT GEN SEQ DNA 324 GENES | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 0042T | B BRGDRFERI ANTB 12 PRTN IGG | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 0045U | ONC BRST DUX CARC IS 12 GENE | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 0047U | ONC PRST8 MRNA 17 GENE ALG | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 0048U | ONC SLD ORG NEO DNA 468 GENE | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 0050U | TRGT GEN SEQ DNA 324 GENES | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 0053U | ONC PRST8 CA FISH ALYS 4 GEN | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 0055U | CARD HRT TRNSPL 96 DNA SEQ | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 0056U | HEM AML DNA GENE REARGMT | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 0060U | TWN ZYG GEN SEQ ALYS CHRMS2 | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |

| CPT and HCPCS Codes That May Require Prior Authorization | Description of Procedure Code | Medical Records Request Information Required |
|--|-------------------------------|---|
| 0067U | ONC BRST IMHCHEM PRFL 4 BMRK | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 0069U | ONC CLRCT MICRORNA MIR-31-3P | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 0070U | CYP2D6 GEN COM&SLCT RAR VRNT | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 0071U | CYP2D6 FULL GENE SEQUENCE | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 0072U | CYP2D6 GEN CYP2D6-2D7 HYBRID | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 0073U | CYP2D6 GEN CYP2D7-2D6 HYBRID | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 0074U | CYP2D6 NONDUPLICATED GENE | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 0075U | CYP2D6 5' GENE DUP/MLT | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 0076U | CYP2D6 3' GENE DUP/MLT | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 0078U | PAIN MGT OPI USE GNOTYP PNL | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 0079U | CMPRTV DNA ALYS MLT SNPS | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 0084U | RBC DNA GNOTYP 10 BLD GROUPS | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 0087U | CRD HRT TRNSPL MRNA 1283 GEN | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 0088U | TRNSPLJ KDN ALGRFT REJ 1494 | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 0089U | ONC MLNMA PRAME & LINC00518 | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 0090U | ONC CUTAN MLNMA MRNA 23 GENE | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 0094U | GENOME RAPID SEQUENCE ALYS | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 0095T | RMVL ARTIFIC DISC ADDL CRVCL | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 0098T | REV ARTIFIC DISC ADDL | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 0101U | HERED COLON CA DO 15 GENES | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 0102T | EXTRACORP SHOCKWV TX ANESTH | Recent history and physical, plan of care, and documentation of medical necessity. |
| 0102U | HERED BRST CA RLTD DO 17 GEN | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |

| CPT and HCPCS Codes That May Require Prior Authorization | Description of Procedure Code | Medical Records Request Information Required |
|--|-------------------------------|--|
| 0103U | HERED OVA CA PNL 24 GENES | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 0111U | ONC COLON CA KRAS&NRAS ALYS | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 0113U | ONC PRST8 PCA3&TMPRSS2-ERG | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 0114U | GI BARRETTS ESOPH VIM&CCNA1 | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 0118U | TRNSPLJ DON-DRV CLL-FR DNA | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 0120U | ONC B CLL LYMPHM MRNA 58 GEN | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 0129U | HERED BRST CA RLTD DO PANEL | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 0130U | HERED COLON CA DO MRNA PNL | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 0131U | HERED BRST CA RLTD DO PNL 13 | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 0132U | HERED OVA CA RLTD DO PNL 17 | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 0133U | HERED PRST8 CA RLTD DO 11 | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 0134U | HERED PAN CA MRNA PNL 18 GEN | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 0135U | HERED GYN CA MRNA PNL 12 GEN | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 0136U | ATM MRNA SEQ ALYS | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 0137U | ATM MRNA SEQ ALYS | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 0138U | BRCA1 BRCA2 MRNA SEQ ALYS | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 0153U | ONC BREAST MRNA 101 GENES | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 0156U | COPY NUMBER SEQUENCE ALYS | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 0157U | APC MRNA SEQ ALYS | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 0158U | MLH1 MRNA SEQ ALYS | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 0159U | MSH2 MRNA SEQ ALYS | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 0160U | MSH6 MRNA SEQ ALYS | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |

| CPT and HCPCS Codes That May Require Prior Authorization | Description of Procedure Code | Medical Records Request Information Required |
|--|---|---|
| 0161U | PMS2 MRNA SEQ ALYS | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 0162U | HERED COLON CA TRGT MRNA PNL | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 0163T | LUMB ARTIF DISKECTOMY ADDL | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 0164T | REMOVE LUMB ARTIF DISC ADDL | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 0165T | REVISE LUMB ARTIF DISC ADDL | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 0169U | NUDT15&TPMT GENE COM VRNT | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 0170U | NEURO ASD RNA NEXT GEN SEQ | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 0171U | TRGT GEN SEQ ALYS PNL DNA 23 | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 0172U | Short description not available at time of update | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 0173U | Short description not available at time of update | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 0175U | Short description not available at time of update | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 0179U | Short description not available at time of update | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 0203U | Short Description not available at time of distribution | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 0204U | Short Description not available at time of distribution | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 0205U | Short Description not available at time of distribution | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 0208U | Short Description not available at time of distribution | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 0209U | Short Description not available at time of distribution | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 0211U | Short Description not available at time of distribution | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 0212U | Short Description not available at time of distribution | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 0213T | NJX PARAVERT W/US CER/THOR | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 0213U | Short Description not available at time of distribution | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 0214T | NJX PARAVERT W/US CER/THOR | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |

| CPT and HCPCS Codes That May Require Prior Authorization | Description of Procedure Code | Medical Records Request Information Required |
|--|---|---|
| 0214U | Short Description not available at time of distribution | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 0215T | NJX PARAVERT W/US CER/THOR | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 0215U | Short Description not available at time of distribution | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 0216T | NJX PARAVERT W/US LUMB/SAC | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 0216U | Short Description not available at time of distribution | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 0217T | NJX PARAVERT W/US LUMB/SAC | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 0217U | Short Description not available at time of distribution | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 0218T | NJX PARAVERT W/US LUMB/SAC | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 0218U | Short Description not available at time of distribution | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 0220U | Short Description not available at time of distribution | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 0228U | ONC PRST8 MA MOLEC PRFL ALG | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 0229U | BCAT1 PROMOTER MTHYLTN ALYS | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 0230U | AR FULL SEQUENCE ANALYSIS | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 0231U | CACNA1A FULL GENE ANALYSIS | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 0232U | CSTB FULL GENE ANALYSIS | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 0233U | FXN GENE ANALYSIS | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 0234U | MECP2 FULL GENE ANALYSIS | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 0235U | PTEN FULL GENE ANALYSIS | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 0236U | SMN1&SMN2 FULL GENE ANALYSIS | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 0237U | CAR ION CHNLPTHY GEN SEQ PNL | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 0238U | ONC LNCH SYN GEN DNA SEQ ALY | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 0239U | TRGT GEN SEQ ALYS PNL 311+ | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |

| CPT and HCPCS Codes That May Require Prior Authorization | Description of Procedure Code | Medical Records Request Information Required |
|--|---|---|
| 0242U | TRGT GEN SEQ ALYS PNL 55-74 | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 0244U | ONC SOLID ORGN DNA 257 GENES | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 0245U | ONC THYR MUT ALYS 10 GEN&37 | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 0246U | RBC DNA GNOTYP 16 BLD GROUPS | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 0250U | ONC SLD ORG NEO DNA 505 GENE | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 0252U | FTL ANEUPLOIDY STR ALYS DNA | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 0253U | RPRDVE MED RNA GEN PRFL 238 | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 0254U | REPRDVE MED ALYS 24 CHRMSM | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 0274T | PERQ LAMOT/LAM CRV/THRC | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 0275T | PERQ LAMOT/LAM LUMBAR | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 0394T | HDR ELCTRNC SKN SURF BRCHYTX | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 0395T | HDR ELCTR NTRST/NTRCV BRCHTX | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 0609T | Short description not available at time of distribution | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 0610T | Short description not available at time of distribution | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 0611T | Short description not available at time of distribution | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 0612T | Short description not available at time of distribution | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 0627T | Short description not available at time of distribution | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 0628T | Short description not available at time of distribution | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 0629T | Short description not available at time of distribution | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 0630T | Short description not available at time of distribution | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 0633T | Short description not available at time of distribution | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 0634T | Short description not available at time of distribution | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |

| CPT and HCPCS Codes That May Require Prior Authorization | Description of Procedure Code | Medical Records Request Information Required |
|--|---|---|
| 0635T | Short description not available at time of distribution | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 0636T | Short description not available at time of distribution | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 0637T | Short description not available at time of distribution | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 0638T | Short description not available at time of distribution | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| 3155F | CYTOGEN TEST MARROW B/4 TX | Recent history and physical, plan of care, and documentation of medical necessity. |
| A0430 | AMBULANCE SERVICE, CONVENTIONAL AIR SERVICES, TRANSPORT, ONE WAY (FIXED WING) | Submit progress notes for last 24 hours prior to transport, physician order including medical records supporting rationale for transport. |
| A0431 | AMBULANCE SERVICE, CONVENTIONAL AIR SERVICES, TRANSPORT, ONE WAY (ROTARY WING) | Submit progress notes for last 24 hours prior to transport, physician order including medical records supporting rationale for transport. |
| A0432 | Paramedic intercept (pi), rural area, transport furnished by a volunteer ambulance company which is prohibited by state law from billing third party payers | Submit progress notes for last 24 hours prior to transport, physician order including medical records supporting rationale for transport. |
| A0433 | Advanced life support, level 2 (als 2) | Submit progress notes for last 24 hours prior to transport, physician order including medical records supporting rationale for transport. |
| A0434 | SPECIALTY CARE TRANSPORT (SCT) | Recent history and physical if applicable and letter of Medical Necessity documenting the need for the requested service. |
| A0435 | FIXED WING AIR MILEAGE, PER STATUTE MILE | Recent history and physical if applicable and letter of Medical Necessity documenting the need for the requested service. |
| A0436 | Rotary wing air mileage, per statute mile | Submit progress notes for last 24 hours prior to transport, physician order including medical records supporting rationale for transport. |
| A4604 | Tubing with integrated heating element for use with positive airway pressure device | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| A7027 | Combination oral/nasal mask, used with continuous positive airway pressure device, each | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| A7028 | Oral cushion for combination oral/nasal mask, replacement only, each | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| A7029 | Nasal pillows for combination oral/nasal mask, replacement only, pair | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |

| CPT and HCPCS Codes That May Require Prior Authorization | Description of Procedure Code | Medical Records Request Information Required |
|--|--|---|
| A7030 | Full face mask used with positive airway pressure device, each | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| A7031 | Face mask interface, replacement for full face mask, each | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| A7032 | Cushion for use on nasal mask interface, replacement only, each | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| A7033 | Pillow for use on nasal cannula type interface, replacement only, pair | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| A7034 | Nasal interface (mask or cannula type) used with positive airway pressure device, with or without head strap | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| A7035 | Headgear used with positive airway pressure device | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| A7036 | Chinstrap used with positive airway pressure device | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| A7037 | Tubing used with positive airway pressure device | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| A7038 | Filter, disposable, used with positive airway pressure device | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| A7039 | Filter, non disposable, used with positive airway pressure device | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| A7044 | Oral interface used with positive airway pressure device, each | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| A7045 | Exhalation port with or without swivel used with accessories for positive airway devices, replacement only | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| A7046 | Water chamber for humidifier, used with positive airway pressure device, replacement, each | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| A9513 | Lutetium Lu 177, dotatate, therapeutic, 1 mCi (Replaced C9031) | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| A9543 | Yttrium Y-90 ibritumomab tiuxetan, therapeutic, per treatment dose, up to 40 millicuries | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| A9590 | Iodine i-131, iobenguane, 1 millicurie | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| A9606 | Radium ra-223 dichloride, therapeutic, per microcurie | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| B4161 | Enteral formula, for pediatrics, hydrolyzed/amino acids and peptide chain proteins, includes fats, carbohydrates, vitamins and minerals, may include fiber, administered through an enteral feeding tube | Letter of medical necessity, including condition being treated. |

| CPT and HCPCS Codes That May Require Prior Authorization | Description of Procedure Code | Medical Records Request Information Required |
|--|---|---|
| C8900 | Magnetic resonance angiography with contrast, abdomen | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| C8901 | Magnetic resonance angiography without contrast, abdomen | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| C8902 | Magnetic resonance angiography without contrast followed by with contrast, abdomen | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| C8903 | Magnetic resonance imaging with contrast, breast; unilateral | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| C8905 | Magnetic resonance imaging without contrast followed by with contrast, breast; unilateral | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| C8906 | Magnetic resonance imaging with contrast, breast; bilateral | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| C8908 | Magnetic resonance imaging without contrast followed by with contrast, breast; bilateral | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| C8909 | Magnetic resonance angiography with contrast, chest (excluding myocardium) | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| C8910 | Magnetic resonance angiography without contrast, chest (excluding myocardium) | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| C8911 | Magnetic resonance angiography without contrast followed by with contrast, chest (excluding myocardium) | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| C8912 | Magnetic resonance angiography with contrast, lower extremity | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| C8913 | Magnetic resonance angiography without contrast, lower extremity | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| C8914 | Magnetic resonance angiography without contrast followed by with contrast, lower extremity | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| C8918 | Magnetic resonance angiography with contrast, pelvis | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| C8919 | Magnetic resonance angiography without contrast, pelvis | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| C8920 | Magnetic resonance angiography without contrast followed by with contrast, pelvis | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| C8931 | Magnetic resonance angiography with contrast, spinal canal and contents | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| C8932 | Magnetic resonance angiography without contrast, spinal canal and contents | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |

| CPT and HCPCS Codes That May Require Prior Authorization | Description of Procedure Code | Medical Records Request Information Required |
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| C8933 | Magnetic resonance angiography without contrast followed by with contrast, spinal canal and contents | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| C8934 | Magnetic resonance angiography with contrast, upper extremity | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| C8935 | Magnetic resonance angiography without contrast, upper extremity | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| C8936 | Magnetic resonance angiography without contrast followed by with contrast, upper extremity | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| C8937 | Computer-aided detection, including computer algorithm analysis of breast MRI image data for lesion detection/characterization, pharmacokinetic analysis, with further physician review for interpretation (list separately in addition to code for primary procedure) | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| C9047 | aTTP | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| C9055 | Zulresso is indicated for the treatment of postpartum depression (PPD) in adults. | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| C9062 | Daratumumab and hyaluronidase-fihj OR Darzalex Faspro | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| C9064 | Mitomycin OR Jelmyto | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| C9065 | Romidepsin (non-lypohilized) | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| C9066 | Sacituzumab govitecan-hziy OR Trodelvy | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| C9257 | Injection, bevacizumab, 0.25 mg | For MMAI plans contact Prime Therapeutics, Fax 877-243-6930 or Call 800-285-9426, website MyPrime.com or CoverMyMeds.com |
| C9257 | Injection, bevacizumab, 0.25 mg | For II Medicaid plans contact eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| C9399 | Unclassified drugs or biologicals | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| C9600 | Percutaneous transcatheter placement of drug eluting intracoronary stent(s), with coronary angioplasty when performed; single major coronary artery or branch | Letter of medical necessity, including condition being treated. |

| CPT and HCPCS Codes That May Require Prior Authorization | Description of Procedure Code | Medical Records Request Information Required |
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| C9757 | Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and excision of herniated intervertebral disc, and repair of annular defect with implantation of bone anchored annular closure device, including annular defect measurement, alignment and sizing assessment, and image guidance; 1 interspace, lumbar | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| C9800 | Dermal injection procedure(s) for facial lipodystrophy syndrome (lds) and provision of radiesse or sculptra dermal filler, including all items and supplies | History and physical or clinical notes. |
| E0194 | Air fluidized bed | History and physical or clinical notes, including anticipated length of use. |
| E0231 | Non-contact wound warming device (temperature control unit, ac adapter and power cord) for use with warming card and wound cover | History and Physical or clinical notes, including anticipated length of use |
| E0232 | Warming card for use with the non contact wound warming device and non contact wound warming wound cover | History and Physical or clinical notes, including anticipated length of use |
| E0250 | Hospital bed, fixed height, with any type side rails, with mattress | History and Physical or clinical notes, including anticipated length of use |
| E0251 | Hospital bed, fixed height, with any type side rails, without mattress | History and Physical or clinical notes, including anticipated length of use |
| E0255 | Hospital bed, variable height, hi-lo, with any type side rails, with mattress | History and Physical or clinical notes, including anticipated length of use |
| E0256 | Hospital bed, variable height, hi-lo, with any type side rails, without mattress | History and Physical or clinical notes, including anticipated length of use |
| E0261 | Hospital bed, semi-electric (head and foot adjustment), with any type side rails, without mattress | History and Physical or clinical notes, including anticipated length of use |
| E0265 | Hospital bed, total electric (head, foot and height adjustments), with any type side rails, with mattress | History and Physical or clinical notes, including anticipated length of use |
| E0266 | Hospital bed, total electric (head, foot and height adjustments), with any type side rails, without mattress | History and Physical or clinical notes, including anticipated length of use |
| E0270 | Hospital bed, institutional type includes: oscillating, circulating and stryker frame, with mattress | History and Physical or clinical notes, including anticipated length of use |

| CPT and HCPCS Codes That May Require Prior Authorization | Description of Procedure Code | Medical Records Request Information Required |
|--|---|--|
| E0271 | Mattress, innerspring | History and physical or clinical notes, including anticipated length of use. |
| E0277 | POWERED PRESSURE-REDUCING AIR MATTRESS | Letter of medical necessity containing the following information: Anticipated length of time patient will require the equipment, Description of medical condition requiring use of this equipment including mobility status. |
| E0290 | Hospital bed, fixed height, without side rails, with mattress | Letter of medical necessity containing the following information: Anticipated length of time patient will require the equipment, Description of medical condition requiring use of this equipment including mobility status |
| E0291 | Hospital bed, fixed height, without side rails, without mattress | Letter of medical necessity containing the following information: Anticipated length of time patient will require the equipment, Description of medical condition requiring use of this equipment including mobility status |
| E0292 | Hospital bed, variable height, hi-lo, without side rails, with mattress | Letter of medical necessity containing the following information: Anticipated length of time patient will require the equipment, Description of medical condition requiring use of this equipment including mobility status |
| E0293 | Hospital bed, variable height, hi-lo, without side rails, without mattress | Letter of medical necessity containing the following information: Anticipated length of time patient will require the equipment, Description of medical condition requiring use of this equipment including mobility status |
| E0294 | Hospital bed, semi-electric (head and foot adjustment), without side rails, with mattress | Letter of medical necessity containing the following information: Anticipated length of time patient will require the equipment, Description of medical condition requiring use of this equipment including mobility status |
| E0295 | Hospital bed, semi-electric (head and foot adjustment), without side rails, without mattress | Letter of medical necessity containing the following information: Anticipated length of time patient will require the equipment, Description of medical condition requiring use of this equipment including mobility status |
| E0296 | Hospital bed, total electric (head, foot and height adjustments), without side rails, with mattress | Letter of medical necessity containing the following information: Anticipated length of time patient will require the equipment, Description of medical condition requiring use of this equipment including mobility status |

| CPT and HCPCS Codes That May Require Prior Authorization | Description of Procedure Code | Medical Records Request Information Required |
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| E0297 | Hospital bed, total electric (head, foot and height adjustments), without side rails, without mattress | Letter of medical necessity containing the following information: Anticipated length of time patient will require the equipment, Description of medical condition requiring use of this equipment including mobility status |
| E0300 | Pediatric crib, hospital grade, fully enclosed, with or without top enclosure | History and physical or clinical notes, including anticipated length of use. |
| E0301 | Hospital bed, heavy duty, extra wide, with weight capacity greater than 350 pounds, but less than or equal to 600 pounds, with any type side rails, without mattress | History and physical or clinical notes, including anticipated length of use |
| E0302 | Hospital bed, extra heavy duty, extra wide, with weight capacity greater than 600 pounds, with any type side rails, without mattress | History and physical or clinical notes, including anticipated length of use |
| E0303 | Hospital bed, heavy duty, extra wide, with weight capacity greater than 350 pounds, but less than or equal to 600 pounds, with any type side rails, with mattress | History and physical or clinical notes, including anticipated length of use |
| E0304 | Hospital bed, extra heavy duty, extra wide, with weight capacity greater than 600 pounds, with any type side rails, with mattress | History and physical or clinical notes, including anticipated length of use |
| E0455 | Oxygen tent, excluding croup or pediatric tents | History and physical or clinical notes, including anticipated length of use. |
| E0465 | Home ventilator, any type, used with invasive interface, (e.g., tracheostomy tube) | History and physical or clinical notes, including anticipated length of use. |
| E0466 | Home ventilator, any type, used with noninvasive interface, (e.g., mask, chest shell) | History and physical or clinical notes, including anticipated length of use. |
| E0470 | Respiratory assist device, bi-level pressure capability, without backup rate feature, used with noninvasive interface, e.g., nasal or facial mask (intermittent assist device with continuous positive airway pressure device) | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |

| CPT and HCPCS Codes That May Require Prior Authorization | Description of Procedure Code | Medical Records Request Information Required |
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| E0471 | Respiratory assist device, bi-level pressure capability, with back-up rate feature, used with noninvasive interface, e.g., nasal or facial mask (intermittent assist device with continuous positive airway pressure device) | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| E0485 | Oral device/appliance used to reduce upper airway collapsibility, adjustable or non-adjustable, prefabricated, includes fitting and adjustment | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| E0486 | Oral device/appliance used to reduce upper airway collapsibility, adjustable or non-adjustable, custom fabricated, includes fitting and adjustment | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| E0561 | Humidifier, non-heated, used with positive airway pressure device | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| E0562 | Humidifier, heated, used with positive airway pressure device | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| E0601 | Continuous positive airway pressure (cpap) device | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| E0635 | Patient lift, electric with seat or sling | Letter of medical necessity containing the following information: Anticipated length of time patient will require the equipment, Description of medical condition requiring use of this equipment including mobility status. |
| E0637 | COMBINATION SIT TO STAND FRAME/TABLE SYSTEM, ANY SIZE INCLUDING PEDIATRIC, WITH SEAT LIFT FEATURE, WITH OR WITHOUT WHEELS | Letter of medical necessity containing the following information: Anticipated length of time patient will require the equipment, Description of medical condition requiring use of this equipment including mobility status. |
| E0638 | Standing frame/table system, one position (e.g., upright, supine or prone stander), any size including pediatric, with or without wheels | Letter of medical necessity, including condition being treated. |
| E0641 | STANDING FRAME/TABLE SYSTEM, MULTI-POSITION (E.G. THREE-WAY STANDER), ANY SIZE INCLUDING PEDIATRIC, WITH OR WITHOUT WHEELS | Letter of medical necessity, including condition being treated. |
| E0642 | STANDING FRAME/TABLE SYSTEM, MOBILE (DYNAMIC STANDER), ANY SIZE INCLUDING PEDIATRIC | Letter of medical necessity, including condition being treated. |
| E0651 | Pneumatic compressor, segmental home model without calibrated gradient pressure | Letter of medical necessity, including condition being treated. |

| CPT and HCPCS Codes That May Require Prior Authorization | Description of Procedure Code | Medical Records Request Information Required |
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| E0652 | PNEUMATIC COMPRESSOR, SEGMENTAL HOME MODEL WITH CALIBRATED GRADIENT PRESSURE | Letter of medical necessity, including condition being treated. |
| E0670 | Segmental pneumatic appliance for use with pneumatic compressor, integrated, 2 full legs and trunk | Letter of medical necessity, including condition being treated. |
| E0675 | PNEUMATIC COMPRESSION DEVICE, HIGH PRESSURE, RAPID INFLATION/DEFLATION CYCLE, FOR ARTERIAL INSUFFICIENCY (UNILATERAL OR BILATERAL SYSTEM) | History and physical including comorbidities, previously tried clinical interventions and operative report if any available. |
| E0676 | Intermittent limb compression device (includes all accessories), not otherwise specified | History and physical including comorbidities, previously tried clinical interventions and operative report if any available. |
| E0691 | Ultraviolet light therapy system, includes bulbs/lamps, timer and eye protection; treatment area 2 sq ft or less | History and physical including comorbidities, previously tried clinical interventions and operative report if any available. |
| E0692 | Ultraviolet light therapy system panel, includes bulbs/lamps, timer and eye protection, 4 ft panel | History and physical including comorbidities, previously tried clinical interventions and operative report if any available. |
| E0693 | Ultraviolet light therapy system panel, includes bulbs/lamps, timer and eye protection, 6 ft panel | History and physical including comorbidities, previously tried clinical interventions and operative report if any available. |
| E0694 | Ultraviolet multidirectional light therapy system in 6 foot cabinet, includes bulbs/lamps, timer and eye protection | Letter of medical necessity containing the following information: Anticipated length of time patient will require the equipment, Description of medical condition requiring use of this equipment including mobility status. |
| E0700 | Safety equipment, device or accessory, any type | Letter of medical necessity containing the following information: Anticipated length of time patient will require the equipment, Description of medical condition requiring use of this equipment including mobility status. |
| E0730 | Transcutaneous electrical nerve stimulation (TENS) device, 4 or more leads, for multiple nerve stimulation | Letter of medical necessity containing the following information: Anticipated length of time patient will require the equipment, Description of medical condition requiring use of this equipment including mobility status. |
| E0747 | Osteogenesis stimulator, electrical, non-invasive, other than spinal applications | Letter of medical necessity containing the following information: Anticipated length of time patient will require the equipment, Description of medical condition requiring use of this equipment including mobility status. |

| CPT and HCPCS Codes That May Require Prior Authorization | Description of Procedure Code | Medical Records Request Information Required |
|--|--|--|
| E0748 | Osteogenesis stimulator, electrical, non-invasive, spinal applications | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| E0749 | Osteogenesis stimulator, electrical, surgically implanted | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| E0760 | Osteogenesis stimulator, low intensity ultrasound, non-invasive | Letter of medical necessity containing the following information: Anticipated length of time patient will require the equipment, Description of medical condition requiring use of this equipment including mobility status. |
| E0764 | Functional neuromuscular stimulation, transcutaneous stimulation of sequential muscle groups of ambulation with computer control, used for walking by spinal cord injured, entire system, after completion of training program | Letter of medical necessity containing the following information: Anticipated length of time patient will require the equipment, Description of medical condition requiring use of this equipment including mobility status. |
| E0766 | Electrical stimulation device used for cancer treatment, includes all accessories, any type | Letter of medical necessity, including condition being treated. |
| E0770 | Functional electrical stimulator, transcutaneous stimulation of nerve and/or muscle groups, any type, complete system, not otherwise specified | Letter of medical necessity containing the following information: Anticipated length of time patient will require the equipment, Description of medical condition requiring use of this equipment including mobility status. |
| E0782 | Infusion pump, implantable, non-programmable (includes all components, e.g., pump, catheter, connectors, etc.) | Letter of medical necessity containing the following information: Anticipated length of time patient will require the equipment, Description of medical condition requiring use of this equipment. |
| E0783 | Infusion pump system, implantable, programmable (includes all components, e.g., pump, catheter, connectors, etc.) | Letter of medical necessity containing the following information: Anticipated length of time patient will require the equipment, Description of medical condition requiring use of this equipment. |
| E0784 | External ambulatory infusion pump, insulin | Letter of medical necessity containing the following information: Anticipated length of time patient will require the equipment, Description of medical condition requiring use of this equipment. |
| E0785 | Implantable intraspinal (epidural/intrathecal) catheter used with implantable infusion pump, replacement | Letter of medical necessity containing the following information: Anticipated length of time patient will require the equipment, Description of medical condition requiring use of this equipment. |
| E0786 | Implantable programmable infusion pump, replacement (excludes implantable intraspinal catheter) | Letter of medical necessity containing the following information: Anticipated length of time patient will require the equipment, Description of medical condition requiring use of this equipment. |

| CPT and HCPCS Codes That May Require Prior Authorization | Description of Procedure Code | Medical Records Request Information Required |
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| E0936 | Continuous passive motion exercise device for use other than knee | Letter of medical necessity containing the following information: Anticipated length of time patient will require the equipment, Description of medical condition requiring use of this equipment including mobility status. |
| E0986 | Manual wheelchair accessory, push rim activated power assist system. | Letter of medical Necessity supporting need for the wheelchair accessory. |
| E1002 | WHEELCHAIR ACCESSORY, POWER SEATING SYSTEM, TILT ONLY | Letter of medical Necessity supporting need for the wheelchair accessory. |
| E1003 | Wheelchair accessory, power seating system, recline only, without shear reduction | Letter of medical Necessity supporting need for the wheelchair accessory. |
| E1004 | Wheelchair accessory, power seating system, recline only, with mechanical shear reduction | Letter of medical Necessity supporting need for the wheelchair accessory. |
| E1005 | Wheelchair accessory, power seating system, recline only, with power shear reduction | Letter of medical Necessity supporting need for the wheelchair accessory. |
| E1006 | Wheelchair accessory, power seating system, combination tilt and recline, without shear reduction | Letter of medical Necessity supporting need for the wheelchair accessory. |
| E1007 | WHEELCHAIR ACCESSORY, POWER SEATING SYSTEM, COMBINATION TILT AND RECLINE, WITH MECHANICAL SHEAR REDUCTION | Letter of medical Necessity supporting need for the wheelchair accessory. |
| E1008 | WHEELCHAIR ACCESSORY, POWER SEATING SYSTEM, COMBINATION TILT AND RECLINE, WITH POWER SHEAR REDUCTION | Letter of medical Necessity supporting need for the wheelchair accessory. |
| E1010 | Wheelchair accessory, addition to power seating system, power leg elevation system, including legrest, pair | Letter of medical Necessity supporting need for the wheelchair accessory. |
| E1012 | Wheelchair accessory, addition to power seating system, center mount power elevating leg rest/platform, complete system, any type, each | Letter of medical Necessity supporting need for the wheelchair accessory. |
| E1028 | Wheelchair accessory, manual swingaway, retractable or removable mounting hardware for joystick, other control interface or positioning accessory | Letter of medical Necessity supporting need for the wheelchair accessory. |
| E1035 | Multi-positional patient transfer system, with integrated seat, operated by care giver, patient weight capacity up to and including 300 lbs | Letter of medical Necessity supporting need for the wheelchair accessory. |

| CPT and HCPCS Codes That May Require Prior Authorization | Description of Procedure Code | Medical Records Request Information Required |
|--|---|---|
| E1036 | Multi-positional patient transfer system, extra-wide, with integrated seat, operated by caregiver, patient weight capacity greater than 300 lbs | Letter of medical Necessity supporting need for the wheelchair accessory. |
| E1037 | Transport chair, pediatric size | Letter of medical Necessity supporting need for the wheelchair accessory. |
| E1038 | Transport chair, adult size, patient weight capacity up to and including 300 pounds | Letter of medical Necessity supporting need for the wheelchair accessory. |
| E1039 | Transport chair, adult size, heavy-duty, patient weight capacity greater than 300 pounds | Letter of medical Necessity supporting need for the wheelchair accessory. |
| E1161 | MANUAL ADULT SIZE WHEELCHAIR, INCLUDES TILT IN SPACE | History and physical to Include the following: diagnosis; abilities and limitations as they relate to the equipment (e.g., degree of independence/ dependence, frequency and nature of the activities the patient performs), duration of medical condition, Past experience if any using similar equipment, evaluation of upper extremity strength. |
| E1220 | Wheelchair; specially sized or constructed, (indicate brand name, model number, if any) and justification | History and physical to Include the following: diagnosis; abilities and limitations as they relate to the equipment (e.g., degree of independence/ dependence, frequency and nature of the activities the patient performs), duration of medical condition, Past experience if any using similar equipment, evaluation of upper extremity strength. |
| E1230 | Power operated vehicle (3- or 4-wheel nonhighway), specify brand name and model number | History and physical to Include the following: diagnosis; abilities and limitations as they relate to the equipment (e.g., degree of independence/ dependence, frequency and nature of the activities the patient performs), duration of medical condition, Past experience if any using similar equipment, evaluation of upper extremity strength. |
| E1231 | Wheelchair, pediatric size, tilt-in-space, rigid, adjustable, with seating system | History and physical to Include the following: diagnosis; abilities and limitations as they relate to the equipment (e.g., degree of independence/ dependence, frequency and nature of the activities the patient performs), duration of medical condition, Past experience if any using similar equipment, evaluation of upper extremity strength. |

| CPT and HCPCS Codes That May Require Prior Authorization | Description of Procedure Code | Medical Records Request Information Required |
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| E1232 | Wheelchair, pediatric size, tilt-in-space, folding, adjustable, with seating system | History and physical to Include the following: diagnosis; abilities and limitations as they relate to the equipment (e.g., degree of independence/ dependence, frequency and nature of the activities the patient performs), duration of medical condition, Past experience if any using similar equipment, evaluation of upper extremity strength. |
| E1233 | Wheelchair, pediatric size, tilt-in-space, rigid, adjustable, without seating system | History and physical to Include the following: diagnosis; abilities and limitations as they relate to the equipment (e.g., degree of independence/ dependence, frequency and nature of the activities the patient performs), duration of medical condition, Past experience if any using similar equipment, evaluation of upper extremity strength. |
| E1234 | Wheelchair, pediatric size, tilt-in-space, folding, adjustable, without seating system | History and physical to Include the following: diagnosis; abilities and limitations as they relate to the equipment (e.g., degree of independence/ dependence, frequency and nature of the activities the patient performs), duration of medical condition, Past experience if any using similar equipment, evaluation of upper extremity strength. |
| E1235 | Wheelchair, pediatric size, rigid, adjustable, with seating system | History and physical to Include the following: diagnosis; abilities and limitations as they relate to the equipment (e.g., degree of independence/ dependence, frequency and nature of the activities the patient performs), duration of medical condition, Past experience if any using similar equipment, evaluation of upper extremity strength. |
| E1236 | Wheelchair, pediatric size, folding, adjustable, with seating system | History and physical to Include the following: diagnosis; abilities and limitations as they relate to the equipment (e.g., degree of independence/ dependence, frequency and nature of the activities the patient performs), duration of medical condition, Past experience if any using similar equipment, evaluation of upper extremity strength. |
| E1237 | Wheelchair, pediatric size, rigid, adjustable, without seating system | History and physical to Include the following: diagnosis; abilities and limitations as they relate to the equipment (e.g., degree of independence/ dependence, frequency and nature of the activities the patient performs), duration of medical condition, Past experience if any using similar equipment, evaluation of upper extremity strength. |

| CPT and HCPCS Codes That May Require Prior Authorization | Description of Procedure Code | Medical Records Request Information Required |
|--|---|---|
| E1238 | Wheelchair, pediatric size, folding, adjustable, without seating system | History and physical to Include the following: diagnosis; abilities and limitations as they relate to the equipment (e.g., degree of independence/ dependence, frequency and nature of the activities the patient performs), duration of medical condition, Past experience if any using similar equipment, evaluation of upper extremity strength. |
| E1239 | Power wheelchair, pediatric size, not otherwise specified | History and physical to Include the following: diagnosis; abilities and limitations as they relate to the equipment (e.g., degree of independence/ dependence, frequency and nature of the activities the patient performs), duration of medical condition, Past experience if any using similar equipment, evaluation of upper extremity strength. |
| E1310 | Whirlpool, nonportable (built-in type) | History and physical to Include the following: diagnosis; abilities and limitations as they relate to the equipment (e.g., degree of independence/ dependence, frequency and nature of the activities the patient performs), duration of medical condition, Past experience if any using similar equipment, evaluation of upper extremity strength. |
| E1399 | Durable medical equipment, miscellaneous | History and physical or clinical notes, including anticipated length of use. |
| E2300 | Wheelchair accessory, power seat elevation system, any type | History and physical to Include the following: diagnosis; abilities and limitations as they relate to the equipment (e.g., degree of independence/ dependence, frequency and nature of the activities the patient performs), duration of medical condition, Past experience if any using similar equipment, evaluation of upper extremity strength. |
| E2301 | Wheelchair accessory, power standing system, any type | History and physical to Include the following: diagnosis; abilities and limitations as they relate to the equipment (e.g., degree of independence/ dependence, frequency and nature of the activities the patient performs), duration of medical condition, Past experience if any using similar equipment, evaluation of upper extremity strength. |
| E2310 | Power wheelchair accessory, electronic connection between wheelchair controller and one power seating system motor, including all related electronics, indicator feature, mechanical function selection switch, and fixed mounting hardware | History and physical or clinical notes, including anticipated length of use. |

| CPT and HCPCS Codes That May Require Prior Authorization | Description of Procedure Code | Medical Records Request Information Required |
|--|--|--|
| E2311 | Power wheelchair accessory, electronic connection between wheelchair controller and two or more power seating system motors, including all related electronics, indicator feature, mechanical function selection switch, and fixed mounting hardware | Letter of medical Necessity supporting need for the wheelchair accessory. |
| E2312 | Power wheelchair accessory, hand or chin control interface, mini-proportional remote joystick, proportional, including fixed mounting hardware | Letter of medical Necessity supporting need for the wheelchair accessory. |
| E2322 | Power wheelchair accessory, hand control interface, multiple mechanical switches, nonproportional, including all related electronics, mechanical stop switch, and fixed mounting hardware | Letter of medical Necessity supporting need for the wheelchair accessory. |
| E2327 | Power wheelchair accessory, head control interface, mechanical, proportional, including all related electronics, mechanical direction change switch, and fixed mounting hardware | Letter of medical Necessity supporting need for the wheelchair accessory. |
| E2328 | Power wheelchair accessory, head control or extremity control interface, electronic, proportional, including all related electronics and fixed mounting hardware | Letter of medical Necessity supporting need for the wheelchair accessory. |
| E2330 | Power wheelchair accessory, head control interface, proximity switch mechanism, nonproportional, including all related electronics, mechanical stop switch, mechanical direction change switch, head array, and fixed mounting hardware | Letter of medical Necessity supporting need for the wheelchair accessory. |
| E2373 | Power wheelchair accessory, hand or chin control interface, compact remote joystick, proportional, including fixed mounting hardware | History and physical or clinical notes, including anticipated length of use. |
| E2402 | Negative pressure wound therapy electrical pump, stationary or portable | Letter of medical necessity, including condition being treated. |
| E2504 | Speech generating device, digitized speech, using prerecorded messages, greater than 20 minutes but less than or equal to 40 minutes recording time | History and physical or clinical notes, including anticipated length of use. |

| CPT and HCPCS Codes That May Require Prior Authorization | Description of Procedure Code | Medical Records Request Information Required |
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| E2506 | Speech generating device, digitized speech, using pre-recorded messages, greater than 40 minutes recording time | Letter of Medical Necessity including length of time equipment needed,functional status if applicable and description of medical condition. |
| E2508 | Speech generating device, synthesized speech, requiring message formulation by spelling and access by physical contact with the device | Letter of Medical Necessity including length of time equipment needed,functional status if applicable and description of medical condition. |
| E2510 | SPEECH GENERATING DEVICE, SYNTHESIZED SPEECH, PERMITTING MULTIPLE METHODS OF MESSAGE FORMULATION AND MULTIPLE METHODS OF DEVICE ACCESS | Letter of Medical Necessity including length of time equipment needed,functional status if applicable and description of medical condition. |
| E2599 | Accessory for speech generating device, not otherwise classified | Letter of Medical Necessity including length of time equipment needed,functional status if applicable and description of medical condition. |
| E2609 | Custom fabricated wheelchair seat cushion, any size | History and physical or clinical notes, including anticipated length of use. |
| E2615 | Positioning wheelchair back cushion, posterior-lateral, width less than 22 in, any height, including any type mounting hardware | History and physical or clinical notes, including anticipated length of use. |
| E2620 | Positioning wheelchair back cushion, planar back with lateral supports, width less than 22 in, any height, including any type mounting hardware | History and physical or clinical notes, including anticipated length of use. |
| E2621 | Positioning wheelchair back cushion, planar back with lateral supports, width 22 in or greater, any height, including any type mounting hardware | History and physical or clinical notes, including anticipated length of use. |
| E2627 | Wheelchair accessory, shoulder elbow, mobile arm support attached to wheelchair, balanced, adjustable Rancho type | History and physical or clinical notes, including anticipated length of use. |
| E2629 | Wheelchair accessory, shoulder elbow, mobile arm support attached to wheelchair, balanced, friction arm support (friction dampening to proximal and distal joints) | History and physical or clinical notes, including anticipated length of use. |
| E8000 | Gait trainer, pediatric size, posterior support, includes all accessories and components | History and physical or clinical notes, including anticipated length of use. |
| E8001 | Gait trainer, pediatric size, upright support, includes all accessories and components | History and physical or clinical notes, including anticipated length of use. |

| CPT and HCPCS Codes That May Require Prior Authorization | Description of Procedure Code | Medical Records Request Information Required |
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| E8002 | Gait trainer, pediatric size, anterior support, includes all accessories and components | History and physical or clinical notes, including anticipated length of use. |
| G0151 | Services performed by a qualified physical therapist in the home health or hospice setting, each 15 minutes | History and physical, chart notes from ordering physician, treatment plan with Letter of medical necessity, including condition being treated. |
| G0152 | Services performed by a qualified occupational therapist in the home health or hospice setting, each 15 minutes | History and physical, chart notes from ordering physician, treatment plan with Letter of medical necessity, including condition being treated. |
| G0153 | SERVICES PERFORMED BY A QUALIFIED SPEECH-LANGUAGE PATHOLOGIST IN THE HOME HEALTH OR HOSPICE SETTING, EACH 15 MINUTES | Recent history and physical, plan of care, and documentation of medical necessity. |
| G0155 | Services of clinical social worker in home health or hospice settings, each 15 minutes | History and physical, chart notes from ordering physician, treatment plan with Letter of medical necessity, including condition being treated. |
| G0156 | Services of home health/hospice aide in home health or hospice settings, each 15 minutes | History and physical, chart notes from ordering physician, treatment plan with Letter of medical necessity, including condition being treated. |
| G0157 | Services performed by a qualified physical therapist assistant in the home health or hospice setting, each 15 minutes | History and physical, chart notes from ordering physician, treatment plan with Letter of medical necessity, including condition being treated. |
| G0158 | Services performed by a qualified occupational therapist assistant in the home health or hospice setting, each 15 minutes | History and physical, chart notes from ordering physician, treatment plan with Letter of medical necessity, including condition being treated. |
| G0159 | Services performed by a qualified physical therapist, in the home health setting, in the establishment or delivery of a safe and effective physical therapy maintenance program, each 15 minutes | History and physical, chart notes from ordering physician, treatment plan with Letter of medical necessity, including condition being treated. |
| G0160 | Services performed by a qualified occupational therapist, in the home health setting, in the establishment or delivery of a safe and effective occupational therapy maintenance program, each 15 minutes | History and physical, chart notes from ordering physician, treatment plan with Letter of medical necessity, including condition being treated. |

| CPT and HCPCS Codes That May Require Prior Authorization | Description of Procedure Code | Medical Records Request Information Required |
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| G0161 | Services performed by a qualified speech-language pathologist, in the home health setting, in the establishment or delivery of a safe and effective speech-language pathology maintenance program, each 15 minutes | History and physical, chart notes from ordering physician, treatment plan with Letter of medical necessity, including condition being treated. |
| G0219 | Pet imaging whole body; melanoma for non-covered indications | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| G0235 | Pet imaging, any site, not otherwise specified | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| G0252 | Pet imaging, full and partial-ring PET scanners only, for initial diagnosis of breast cancer and/or surgical planning for breast cancer (e.g., initial staging of axillary lymph nodes) | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| G0260 | Injection procedure for sacroiliac joint; provision of anesthetic, steroid and/or other therapeutic agent, with or without arthrography | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| G0281 | Electrical stimulation, (unattended), to one or more areas, for chronic stage iii and stage iv pressure ulcers, arterial ulcers, diabetic ulcers, and venous stasis ulcers not demonstrating measurable signs of healing after 30 days of conventional care, as part of a therapy plan of care | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| G0282 | Electrical stimulation, (unattended), to one or more areas, for wound care other than described in G0281 | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| G0283 | Electrical stimulation (unattended), to one or more areas for indication(s) other than wound care, as part of a therapy plan of care | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| G0297 | Low dose ct scan (ldct) for lung cancer screening | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| G0299 | Direct skilled nursing services of a registered nurse (rn) in the home health or hospice setting, each 15 minutes | History and physical, chart notes from ordering physician, treatment plan with Letter of medical necessity, including condition being treated. |
| G0300 | Direct skilled nursing services of a license practical nurse (lpn) in the home health or hospice setting, each 15 minutes | History and physical, chart notes from ordering physician, treatment plan with Letter of medical necessity, including condition being treated. |

| CPT and HCPCS Codes That May Require Prior Authorization | Description of Procedure Code | Medical Records Request Information Required |
|--|--|--|
| G0329 | Electromagnetic therapy, to one or more areas for chronic stage iii and stage iv pressure ulcers, arterial ulcers, diabetic ulcers and venous stasis ulcers not demonstrating measurable signs of healing after 30 days of conventional care as part of a therapy plan of care | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| G0339 | Image-guided robotic linear accelerator-based stereotactic radiosurgery, complete course of therapy in one session or first session of fractionated treatment | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| G0340 | Image-guided robotic linear accelerator-based stereotactic radiosurgery, delivery including collimator changes and custom plugging, fractionated treatment, all lesions, per session, second through fifth sessions, maximum five sessions per course of treatment | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| G0398 | Home sleep study test (hst) with type ii portable monitor, unattended; minimum of 7 channels: eeg, eog, emg, ecg/heart rate, airflow, respiratory effort and oxygen saturation | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| G0399 | Home sleep test (hst) with type iii portable monitor, unattended; minimum of 4 channels: 2 respiratory movement/airflow, 1 ecg/heart rate and 1 oxygen saturation | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| G0400 | Home sleep test (hst) with type iv portable monitor, unattended; minimum of 3 channels | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| G0422 | INTENSIVE CARDIAC REHABILITATION; WITH OR WITHOUT CONTINUOUS ECG MONITORING WITH EXERCISE, PER SESSION | History and physical, chart notes from ordering physician, treatment plan with Letter of medical necessity, including condition being treated. |
| G0423 | INTENSIVE CARDIAC REHABILITATION; WITH OR WITHOUT CONTINUOUS ECG MONITORING; WITHOUT EXERCISE, PER SESSION | History and physical, chart notes from ordering physician, treatment plan with Letter of medical necessity, including condition being treated. |
| G0429 | Dermal filler injection(s) for the treatment of facial lipodystrophy syndrome (lds) (e.g., as a result of highly active antiretroviral therapy) | History and physical, chart notes from ordering physician, treatment plan with Letter of medical necessity, including condition being treated. |

| CPT and HCPCS Codes That May Require Prior Authorization | Description of Procedure Code | Medical Records Request Information Required |
|--|---|--|
| G0451 | Development testing, with interpretation and report, per standardized instrument form | History and physical, chart notes from ordering physician, treatment plan with Letter of medical necessity, including condition being treated. |
| G6001 | Ultrasonic guidance for placement of radiation therapy fields | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| G6002 | Stereoscopic x-ray guidance for localization of target volume for the delivery of radiation therapy | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| G6003 | Radiation treatment delivery, single treatment area, single port or parallel opposed ports, simple blocks or no blocks: up to 5 mev | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| G6004 | Radiation treatment delivery, single treatment area, single port or parallel opposed ports, simple blocks or no blocks: 6-10 mev | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| G6005 | Radiation treatment delivery, single treatment area, single port or parallel opposed ports, simple blocks or no blocks: 11-19 mev | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| G6006 | Radiation treatment delivery, single treatment area, single port or parallel opposed ports, simple blocks or no blocks: 20 mev or greater | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| G6007 | Radiation treatment delivery, 2 separate treatment areas, 3 or more ports on a single treatment area, use of multiple blocks: up to 5 mev | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| G6008 | Radiation treatment delivery, 2 separate treatment areas, 3 or more ports on a single treatment area, use of multiple blocks: 6-10 mev | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| G6009 | Radiation treatment delivery, 2 separate treatment areas, 3 or more ports on a single treatment area, use of multiple blocks: 11-19 mev | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| G6010 | Radiation treatment delivery, 2 separate treatment areas, 3 or more ports on a single treatment area, use of multiple blocks: 20 mev or greater | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |

| CPT and HCPCS Codes That May Require Prior Authorization | Description of Procedure Code | Medical Records Request Information Required |
|--|---|---|
| G6011 | Radiation treatment delivery,3 or more separate treatment areas, custom blocking, tangential ports, wedges, rotational beam, compensators, electron beam; up to 5 mev | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| G6012 | Radiation treatment delivery,3 or more separate treatment areas, custom blocking, tangential ports, wedges, rotational beam, compensators, electron beam; 6-10 mev | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| G6013 | Radiation treatment delivery,3 or more separate treatment areas, custom blocking, tangential ports, wedges, rotational beam, compensators, electron beam; 11-19 mev | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| G6014 | Radiation treatment delivery,3 or more separate treatment areas, custom blocking, tangential ports, wedges, rotational beam, compensators, electron beam; 20 mev or greater | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| G6015 | Intensity modulated treatment delivery, single or multiple fields/arcs, via narrow spatially and temporally modulated beams, binary, dynamic mlc, per treatment session | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| G6016 | Compensator-based beam modulation treatment delivery of inverse planned treatment using 3 or more high resolution (milled or cast) compensator, convergent beam modulated fields, per treatment session | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| G6017 | Intra-fraction localization and tracking of target or patient motion during delivery of radiation therapy (eg, 3d positional tracking, gating, 3d surface tracking), each fraction of treatment | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| G9143 | Warfarin responsiveness testing by genetic technique using any method, any number of specimen(s) | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J0129 | Injection, abatacept, 10 mg (code may be used for medicare when drug administered under the direct supervision of a physician, not for use when drug is self administered) | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |

| CPT and HCPCS Codes That May Require Prior Authorization | Description of Procedure Code | Medical Records Request Information Required |
|--|---|---|
| J0178 | Injection, aflibercept, 1 mg | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J0179 | Injection, brolocizumab-dbl, 1 mg | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J0180 | Injection, agalsidase beta, 1 mg | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J0202 | Injection, alemtuzumab, 1 mg | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J0207 | Injection, amifostine, 500 mg | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J0221 | Injection, alglucosidase alfa, (lumizyme), 10 mg | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J0223 | Givosiran | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J0256 | Injection, alpha 1 proteinase inhibitor (human), not otherwise specified, 10 mg | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J0257 | Injection, alpha 1 proteinase inhibitor (human), (glassia), 10 mg | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J0364 | Injection, apomorphine hydrochloride, 1 mg | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J0490 | Injection, belimumab, 10 mg | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J0517 | Fasenra | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J0565 | Zinplava 1000 MG/40ML SOLN J0565 Injection, bezlotoxumab, 10 mg | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J0584 | Crysvita | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J0585 | Injection, onabotulinumtoxina, 1 unit | For MMAI plans contact Prime Therapeutics, Fax 877-243-6930 or Call 800-285-9426, website MyPrime.com or CoverMyMeds.com |
| J0585 | Injection, onabotulinumtoxina, 1 unit | For II Medicaid plans contact eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J0586 | Injection, abobotulinumtoxina, 5 units | For MMAI plans contact Prime Therapeutics, Fax 877-243-6930 or Call 800-285-9426, website MyPrime.com or CoverMyMeds.com |
| J0586 | Injection, abobotulinumtoxina, 5 units | For II Medicaid plans contact eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J0587 | Injection, rimabotulinumtoxinb, 100 units | For MMAI plans contact Prime Therapeutics, Fax 877-243-6930 or Call 800-285-9426, website MyPrime.com or CoverMyMeds.com |
| J0587 | Injection, rimabotulinumtoxinb, 100 units | For II Medicaid plans contact eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |

| CPT and HCPCS Codes That May Require Prior Authorization | Description of Procedure Code | Medical Records Request Information Required |
|--|---|---|
| J0588 | Injection, incobotulinumtoxin a, 1 unit | For MMAI plans contact Prime Therapeutics, Fax 877-243-6930 or Call 800-285-9426, website MyPrime.com or CoverMyMeds.com |
| J0588 | Injection, incobotulinumtoxin a, 1 unit | For II Medicaid plans contact eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J0596 | Injection, c1 esterase inhibitor (recombinant), ruconest, 10 units | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J0597 | Injection, c-1 esterase inhibitor (human), berinert, 10 units | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J0598 | Injection, c-1 esterase inhibitor (human), cinryze, 10 units | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J0606 | 5 MG/ML SOLN J0606 Injection, etelcalcetide, 0.1 mg and 2.5 MG/0.5ML SOLN J0606 Injection, etelcalcetide, 0.1 mg and 10 MG/2ML SOLN J0606 Injection, etelcalcetide, 0.1 | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J0638 | Injection, canakinumab, 1 mg | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J0640 | Injection, leucovorin calcium, per 50 mg | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J0641 | Injection, levoleucovorin calcium, 0.5 mg | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J0642 | Levoleucovorin | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J0775 | Injection, collagenase, clostridium histolyticum, 0.01 mg | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J0791 | Crizanlizumab-tmca (Adakveo) | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J0800 | Injection, corticotropin, up to 40 units | For MMAI plans contact Prime Therapeutics, Fax 877-243-6930 or Call 800-285-9426, website MyPrime.com or CoverMyMeds.com |
| J0800 | Injection, corticotropin, up to 40 units | For II Medicaid plans contact eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J0885 | Injection, epoetin alfa, (for non-esrd use), 1000 units | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J0888 | Injection, epoetin beta, 1 microgram, (for non esrd use) | For MMAI plans contact Prime Therapeutics, Fax 877-243-6930 or Call 800-285-9426, website MyPrime.com or CoverMyMeds.com |
| J0888 | Injection, epoetin beta, 1 microgram, (for non esrd use) | For II Medicaid plans contact eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J0894 | Injection, decitabine, 1 mg | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J0896 | Luspatercept-aamt OR Reblozyl | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |

| CPT and HCPCS Codes That May Require Prior Authorization | Description of Procedure Code | Medical Records Request Information Required |
|--|---|---|
| J0896 | Luspatercept-aamt | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J0897 | Injection, denosumab, 1 mg | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J1290 | Injection, ecallantide, 1 mg | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J1300 | Injection, eculizumab, 10 mg | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J1301 | Radicava | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J1322 | Injection, elosulfase alfa, 1 mg | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J1325 | Injection, epoprostenol, 0.5 mg | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J1427 | Viltepso | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J1428 | 500 MG/10ML SOLN J1428 Injection, eteplirsen, 10 mg and Exondys 51 100 MG/2ML SOLN J1428 Injection, eteplirsen, 10 mg | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J1429 | Golodirsen/Vyondys | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J1442 | Injection, filgrastim (g-csf), eXcludes biosimilars, 1 microgram | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J1453 | Injection, fosaprepitant, 1 mg | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J1454 | Fosnetupitant/Palonosetron | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J1458 | Injection, galsulfase, 1 mg | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J1459 | Injection, immune globulin (privigen), intravenous, non-lyophilized (e.g., liquid), 500 mg | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J1554 | Asceniv | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J1555 | Injection, immune globulin, 100 mg | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J1556 | Injection, immune globulin (bivigam), 500 mg | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J1557 | Injection, immune globulin, (gammapleX), intravenous, non- lyophilized (e.g., liquid), 500 mg | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J1559 | Injection, immune globulin (hizentra), 100 mg | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |

| CPT and HCPCS Codes That May Require Prior Authorization | Description of Procedure Code | Medical Records Request Information Required |
|--|--|---|
| J1561 | Injection, immune globulin, (gamunex-c/gammaked), non-lyophilized (e.g., liquid), 500 mg | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J1566 | Injection, immune globulin, intravenous, lyophilized (e.g., powder), not otherwise specified, 500 mg | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J1568 | Injection, immune globulin, (octagam), intravenous, non-lyophilized (e.g., liquid), 500 mg | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J1569 | Injection, immune globulin, (gammagard liquid), non-lyophilized, (e.g., liquid), 500 mg | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J1572 | Injection, immune globulin, (flebogamma/flebogamma dif), intravenous, non-lyophilized (e.g., liquid), 500 mg | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J1575 | Injection, immune globulin/hyaluronidase, (hyqvia), 100 mg immunoglobulin | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J1602 | Injection, golimumab, 1 mg, for intravenous use | For MMAI plans contact Prime Therapeutics, Fax 877-243-6930 or Call 800-285-9426, website MyPrime.com or CoverMyMeds.com |
| J1602 | Injection, golimumab, 1 mg, for intravenous use | For II Medicaid plans contact eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J1627 | Injection, granisetron, extended-release, 0.1 mg | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J1632 | Brexanolone | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J1743 | Injection, idursulfase, 1 mg | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J1744 | Injection, icatibant, 1 mg | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J1745 | Injection infliximab, 10 mg | For MMAI plans contact Prime Therapeutics, Fax 877-243-6930 or Call 800-285-9426, website MyPrime.com or CoverMyMeds.com |
| J1745 | Injection infliximab, 10 mg | For II Medicaid plans contact eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J1746 | Troglarzo | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J1786 | Injection, imiglucerase, 10 units | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J1823 | Uplizna | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |

| CPT and HCPCS Codes That May Require Prior Authorization | Description of Procedure Code | Medical Records Request Information Required |
|--|---|---|
| J1930 | Injection, lanreotide, 1 mg | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J1931 | Injection, laronidase, 0.1 mg | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J1950 | Leuprolide acetate, per 3.75 mg | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J2182 | 100 MG SOLR J2182 Injection, mepolizumab, 1 mg | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J2323 | Injection, natalizumab, 1 mg | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J2326 | Injection, nusinersen, 0.1 mg | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J2350 | 300 MG/10ML SOLN J2350 Injection, ocrelizumab, 1 mg. New code effective 1/1/18 previously coded J3590 Go live was 11/1/17 | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J2353 | Injection, octreotide, depot form for intramuscular injection, 1 mg | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J2354 | Injection, octreotide, non-depot form for subcutaneous or intravenous injection, 25 mcg | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J2357 | Injection, omalizumab, 5 mg | For MMAI plans contact Prime Therapeutics, Fax 877-243-6930 or Call 800-285-9426, website MyPrime.com or CoverMyMeds.com |
| J2357 | Injection, omalizumab, 5 mg | For II Medicaid plans contact eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J2430 | Injection, pamidronate disodium, per 30 mg | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J2469 | Injection, palonosetron hcl, 25 mcg | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J2502 | Injection, pasireotide long acting, 1 mg | For MMAI plans contact Prime Therapeutics, Fax 877-243-6930 or Call 800-285-9426, website MyPrime.com or CoverMyMeds.com |
| J2502 | Injection, pasireotide long acting, 1 mg | For II Medicaid plans contact eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J2503 | Injection, pegaptanib sodium, 0.3 mg | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J2505 | Injection, pegfilgrastim, 6 mg | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J2507 | Injection, pegloticase, 1 mg | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J2562 | Injection, pleriXafor, 1 mg | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |

| CPT and HCPCS Codes That May Require Prior Authorization | Description of Procedure Code | Medical Records Request Information Required |
|--|--|---|
| J2778 | Injection, ranibizumab, 0.1 mg | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J2783 | Injection, rasburicase, 0.5 mg | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J2786 | 100 MG/10ML SOLN J2786 Injection, reslizumab, 1 mg | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J2793 | Injection, rilonacept, 1 mg | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J2796 | Injection, romiplostim, 10 micrograms | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J2840 | Kanuma 20 MG/10ML SOLN J2840 Injection, sebelipase alfa, 1 mg | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J2860 | Injection, siltuximab, 10 mg | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J3032 | Eptinezumab-jjmr (Vyepiti) | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J3060 | Injection, taliglucerase alfa, 10 units | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J3111 | Evenity is indicated for the treatment of osteoporosis in postmenopausal women at high risk for fracture, defined as a history of osteoporotic fracture, or multiple risk for fracture; or patients who have failed or are intolerant to other available osteoporosis therapy. | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J3241 | Teprotumumab-trbw | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J3245 | Ilumya | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J3262 | Injection, tocilizumab, 1 mg | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J3285 | Injection, treprostinil, 1 mg | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J3304 | Zilretta | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J3315 | Injection, triptorelin pamoate, 3.75 mg | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J3316 | Triptodur | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J3357 | Stelara 45 MG/0.5ML SOLN J3357 Ustekinumab, for subcutaneous injection, 1 mg and Stelara 90 MG/ML SOLN J3357 Ustekinumab, for subcutaneous injection, 1 mg | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |

| CPT and HCPCS Codes That May Require Prior Authorization | Description of Procedure Code | Medical Records Request Information Required |
|--|---|--|
| J3358 | Stelara 130 MG/26ML SOLN J3358 Ustekinumab, for intravenous injection, 1 mg | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J3380 | Injection, vedolizumab, 1 mg | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J3385 | Injection, velaglucerase alfa, 100 units | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J3397 | Mepsevii | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J3398 | Luxturna | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J3399 | Zolgensma | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J3489 | Injection, zoledronic acid, 1 mg | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J3490 | Unclassified drugs | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J3590 | Unclassified biologics | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J7318 | Durolane | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J7320 | Hyaluronan or derivative, genvisc 850, for intra-articular injection, 1 mg | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J7321 | Hyaluronan or derivative, hyalgan or supartz, for intra-articular injection, per dose | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J7322 | 24 MG/3ML SOSY J7322 Hyaluronan or derivative, for intra-articular injection, 1 mg | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J7323 | Hyaluronan or derivative, euflexxa, for intra-articular injection, per dose | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J7324 | Hyaluronan or derivative, orthovisc, for intra-articular injection, per dose | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J7325 | Hyaluronan or derivative, synvisc or synvisc-one, for intra-articular injection, 1 mg | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J7326 | Hyaluronan or derivative, gel-one, for intra-articular injection, per dose | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J7327 | Hyaluronan or derivative, monovisc, for intra-articular injection, per dose | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J7328 | Hyaluronan or derivative, for intra-articular injection, 0.1 mg | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J7329 | TriVisc | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |

| CPT and HCPCS Codes That May Require Prior Authorization | Description of Procedure Code | Medical Records Request Information Required |
|--|---|---|
| J7332 | Hyaluronan or derivative, triluron, for intra-articular injection, 1 mg | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J7333 | Visco-3 | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J7352 | Scenesse | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J7353 | Hyaluronan or derivative, synvisc or synvisc-one, for intra-articular injection, 1 mg | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J9000 | Injection, doxorubicin hydrochloride, 10 mg | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J9015 | Injection, aldesleukin, per single use vial | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J9017 | Injection, arsenic trioxide, 1 mg | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J9019 | Injection, asparaginase (erwinaze), 1,000 iu | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J9022 | Injection, atezolizumab, 10 mg | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J9023 | Injection, avelumab, 10 mg | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J9025 | Injection, azacitidine, 1 mg | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J9027 | Injection, clofarabine, 1 mg | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J9030 | BCG live intravesical instillation, 1 mg | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J9032 | Injection, belinostat, 10 mg | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J9033 | Injection, bendamustine hcl, 1 mg | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J9034 | Injection, bendamustine HCl (bendeka), 1 mg | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J9036 | Bendamustine HCL | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J9037 | Blenrep | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J9039 | Injection, blinatumomab, 1 microgram | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J9040 | Injection, bleomycin sulfate, 15 units | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J9041 | Injection, bortezomib, 0.1 mg | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |

| CPT and HCPCS Codes That May Require Prior Authorization | Description of Procedure Code | Medical Records Request Information Required |
|--|--|---|
| J9042 | Injection, brentuximab vedotin, 1 mg | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J9043 | Injection, cabazitaxel, 1 mg | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J9044 | Bortezomib | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J9045 | Injection, carboplatin, 50 mg | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J9047 | Injection, carfilzomib, 1 mg | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J9050 | Injection, carmustine, 100 mg | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J9055 | Injection, cetuximab, 10 mg | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J9057 | Copanlisib | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J9060 | Injection, cisplatin, powder or solution, 10 mg | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J9065 | Injection, cladribine, per 1 mg | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J9070 | Cyclophosphamide, 100 mg | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J9098 | Injection, cytarabine liposome, 10 mg | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J9100 | Injection, cytarabine, 100 mg | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J9118 | Calaspargase pegol-mknl | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J9119 | Cemiplimab-rwlc | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J9120 | Injection, dactinomycin, 0.5 mg | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J9130 | Dacarbazine, 100 mg | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J9144 | Darzalex Faspro | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J9145 | Injection, daratumumab, 10 mg | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J9150 | Injection, daunorubicin, 10 mg | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J9153 | Injection, liposomal, 1 mg daunorubicin and 2.27 mg cytarabine | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J9155 | Injection, degarelix, 1 mg | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |

| CPT and HCPCS Codes That May Require Prior Authorization | Description of Procedure Code | Medical Records Request Information Required |
|--|--|---|
| J9171 | Injection, docetaXel, 1 mg | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J9173 | Durvalumab | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J9175 | Injection, eliott's b solution, 1 ml | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J9176 | Injection, elotuzumab, 1 mg | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J9177 | Enfortumb vedotin-ejfv OR Padcev | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J9178 | Injection, epirubicin hcl, 2 mg | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J9179 | Injection, eribulin mesylate, 0.1 mg | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J9181 | Injection, etoposide, 10 mg | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J9185 | Injection, fludarabine phosphate, 50 mg | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J9190 | Injection, fluorouracil, 500 mg | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J9198 | Gemcitabine HCL in NaCl OR Infugem | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J9200 | Injection, floXuridine, 500 mg | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J9201 | Injection, gemcitabine hydrochloride, 200 mg | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J9202 | Goserelin acetate implant, per 3.6 mg | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J9203 | Injection, gemtuzumab ozogamicin, 0.1 mg | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J9204 | Mogamulizumab-kpkc | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J9205 | Injection, irinotecan liposome, 1 mg | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J9206 | Injection, irinotecan, 20 mg | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J9207 | Injection, iXabepilone, 1 mg | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J9208 | Injection, ifosfamide, 1 gram | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J9209 | Injection, mesna, 200 mg | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J9211 | Injection, idarubicin hydrochloride, 5 mg | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |

| CPT and HCPCS Codes That May Require Prior Authorization | Description of Procedure Code | Medical Records Request Information Required |
|--|---|---|
| J9214 | Injection, interferon, alfa-2b, recombinant, 1 million units | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J9216 | Injection, interferon, gamma 1-b, 3 million units | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J9217 | Leuprolide acetate (for depot suspension), 7.5 mg | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J9218 | Leuprolide acetate, per 1 mg | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J9223 | Zepzelca | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J9225 | Histrelin implant (vantas), 50 mg | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J9226 | Histrelin implant (supprelin la), 50 mg | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J9227 | Isatuximab-irfc OR Sarclisa | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J9228 | Injection, ipilimumab, 1 mg | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J9229 | Injection, inotuzumab ozogamicin, 0.1 mg | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J9230 | Injection, mechlorethamine hydrochloride, (nitrogen mustard), 10 mg | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J9245 | Injection, melphalan hydrochloride, 50 mg | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J9246 | Melphalan HCL OR Evomela | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J9250 | MethotreXate sodium, 5 mg | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J9260 | Methotrexate Sodium (J9260: 50mg) | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J9261 | Injection, nelarabine, 50 mg | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J9262 | Injection, omacetaXine mepesuccinate, 0.01 mg | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J9263 | Injection, oXaliplatin, 0.5 mg | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J9264 | Injection, paclitaXel protein-bound particles, 1 mg | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J9266 | Injection, pegaspargase, per single dose vial | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J9267 | Injection, paclitaXel, 1 mg | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |

| CPT and HCPCS Codes That May Require Prior Authorization | Description of Procedure Code | Medical Records Request Information Required |
|--|-----------------------------------|---|
| J9268 | Injection, pentostatin, 10 mg | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J9269 | Tagraxofusp-erzs | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J9271 | Injection, pembrolizumab, 1 mg | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J9280 | Injection, mitomycin, 5 mg | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J9281 | Jelmyto | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J9285 | Injection, olaratumab, 10 mg | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J9293 | Novantrone | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J9295 | Injection, necitumumab, 1 mg | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J9299 | Injection, nivolumab, 1 mg | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J9301 | Injection, obinutuzumab, 10 mg | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J9302 | Injection, ofatumumab, 10 mg | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J9303 | Injection, panitumumab, 10 mg | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J9304 | Pemetrexed OR Pempfexy | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J9305 | Injection, pemetreXed, 10 mg | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J9306 | Injection, pertuzumab, 1 mg | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J9307 | Injection, pralatreXate, 1 mg | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J9308 | Injection, ramucirumab, 5 mg | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J9309 | Polatuzumab vedotin-piiq | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J9311 | Rituximab and Hyaluronidase Human | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J9312 | Rituxan | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J9313 | Moxetumomab pasudotox-tdfk | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J9315 | Injection, romidepsin, 1 mg | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |

| CPT and HCPCS Codes That May Require Prior Authorization | Description of Procedure Code | Medical Records Request Information Required |
|--|---|---|
| J9316 | Phesgo | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J9317 | Trodelvy | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J9320 | Injection, streptozocin, 1 gram | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J9325 | Injection, talimogene laherparepvec, per 1 million plaque forming units | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J9328 | Injection, temozolomide, 1 mg | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J9330 | Injection, temsirolimus, 1 mg | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J9340 | Injection, thiotepa, 15 mg | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J9349 | Monjuvi | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J9351 | Injection, topotecan, 0.1 mg | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J9352 | Injection, trabectedin, 0.1 mg | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J9354 | Injection, ado-trastuzumab emtansine, 1 mg | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J9355 | Injection, trastuzumab, 10 mg | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J9356 | Trastuzumab and hyaluronidase-oysk | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J9357 | Injection, valrubicin, intravesical, 200 mg | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J9358 | Fam-trastuzumab deruxtecan-nxki OR Enhertu | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J9360 | Injection, vinblastine sulfate, 1 mg | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J9370 | Vincristine sulfate, 1 mg | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J9371 | Injection, vincristine sulfate liposome, 1 mg | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J9390 | Injection, vinorelbine tartrate, 10 mg | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J9395 | Injection, fulvestrant, 25 mg | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J9400 | Injection, ziv-aflibercept, 1 mg | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |

| CPT and HCPCS Codes That May Require Prior Authorization | Description of Procedure Code | Medical Records Request Information Required |
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| J9600 | Injection, porfimer sodium, 75 mg | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| J9999 | Unclassified neoplastic | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| K0004 | High strength, lightweight wheelchair | History and physical or clinical notes, including anticipated length of use. |
| K0005 | Ultralightweight wheelchair | History and physical or clinical notes, including anticipated length of use. |
| K0006 | Heavy-duty wheelchair | History and physical or clinical notes, including anticipated length of use. |
| K0007 | Extra heavy-duty wheelchair | History and physical or clinical notes, including anticipated length of use. |
| K0008 | Custom manual wheelchair/base | History and physical or clinical notes, including anticipated length of use. |
| K0009 | Other manual wheelchair/base | History and physical or clinical notes, including anticipated length of use. |
| K0010 | Standard-weight frame motorized/power wheelchair | History and physical or clinical notes, including anticipated length of use. |
| K0011 | Standard-weight frame motorized/power wheelchair with programmable control parameters for speed adjustment, tremor dampening, acceleration control and braking | History and physical or clinical notes, including anticipated length of use. |
| K0012 | Lightweight portable motorized/power wheelchair | History and physical or clinical notes, including anticipated length of use. |
| K0013 | Custom motorized/power wheelchair base | History and physical or clinical notes, including anticipated length of use. |
| K0014 | OTHER MOTORIZED/POWER WHEELCHAIR BASE | History and physical to Include the following: diagnosis; abilities and limitations as they relate to the equipment (e.g., degree of independence/ dependence, frequency and nature of the activities the patient performs), duration of medical condition, Past experience if any using similar equipment, evaluation of upper extremity strength. Documented inability to propel a manual chair. |
| K0108 | Wheelchair component or accessory, not otherwise specified | History and physical to Include the following: diagnosis; abilities and limitations as they relate to the equipment (e.g., degree of independence/ dependence, frequency and nature of the activities the patient performs), duration of medical condition, Past experience if any using similar equipment, evaluation of upper extremity strength. Documented inability to propel a manual chair. |

| CPT and HCPCS Codes That May Require Prior Authorization | Description of Procedure Code | Medical Records Request Information Required |
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| K0455 | Infusion pump used for uninterrupted parenteral administration of medication, (e.g., epoprostenol or treprostinol) | History and physical to Include the following: diagnosis; abilities and limitations as they relate to the equipment (e.g., degree of independence/ dependence, frequency and nature of the activities the patient performs), duration of medical condition, Past experience if any using similar equipment, evaluation of upper extremity strength. Documented inability to propel a manual chair. |
| K0606 | Aed garment w elec analysis | Recent history and physical, plan of care, and documentation of medical necessity. |
| K0739 | Repair or nonroutine service for durable medical equipment other than oxygen equipment requiring the skill of a technician, labor component, per 15 minutes | Recent History and Physical, plan of care, and documentation of medical necessity |
| K0800 | Power operated vehicle, group 1 standard, patient weight capacity up to and including 300 pounds | Recent History and Physical, plan of care, and documentation of medical necessity |
| K0801 | Power operated vehicle, group 1 heavy duty, patient weight capacity 301 to 450 pounds | Recent history and physical, plan of care, and documentation of medical necessity. |
| K0806 | Power operated vehicle, group 2 standard, patient weight capacity up to and including 300 pounds | Recent History and Physical, plan of care, and documentation of medical necessity |
| K0808 | Power operated vehicle, group 2 very heavy duty, patient weight capacity 451 to 600 pounds | Recent history and physical, plan of care, and documentation of medical necessity. |
| K0812 | Power operated vehicle, not otherwise classified | Recent History and Physical, plan of care, and documentation of medical necessity |
| K0813 | Power wheelchair, group 1 standard, portable, sling/solid seat and back, patient weight capacity up to and including 300 pounds | History and physical or clinical notes, including anticipated length of use. |
| K0814 | Power wheelchair, group 1 standard, portable, captains chair, patient weight capacity up to and including 300 pounds | Recent history and physical, plan of care, and documentation of medical necessity. |
| K0815 | Power wheelchair, group 1 standard, sling/solid seat and back, patient weight capacity up to and including 300 pounds | Recent history and physical, plan of care, and documentation of medical necessity. |
| K0816 | Power wheelchair, group 1 standard, captain's chair, patient weight capacity up to and including 300 pounds | Recent history and physical, plan of care, and documentation of medical necessity. |

| CPT and HCPCS Codes That May Require Prior Authorization | Description of Procedure Code | Medical Records Request Information Required |
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| K0820 | Power wheelchair, group 2 standard, portable, sling/solid seat/back, patient weight capacity up to and including 300 pounds | Recent history and physical, plan of care, and documentation of medical necessity. |
| K0821 | Power wheelchair, group 2 standard, portable, captain's chair, patient weight capacity up to and including 300 pounds | Recent history and physical, plan of care, and documentation of medical necessity. |
| K0822 | POWER WHEELCHAIR, GROUP 2 STANDARD, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS | History and physical to Include the following: diagnosis; abilities and limitations as they relate to the equipment (e.g., degree of independence/ dependence, frequency and nature of the activities the patient performs), duration of medical condition, Past experience if any using similar equipment, evaluation of upper extremity strength. |
| K0823 | Power wheelchair, group 2 standard, captain's chair, patient weight capacity up to and including 300 pounds | History and physical to Include the following: diagnosis; abilities and limitations as they relate to the equipment (e.g., degree of independence/ dependence, frequency and nature of the activities the patient performs), duration of medical condition, Past experience if any using similar equipment, evaluation of upper extremity strength. |
| K0824 | Power wheelchair, group 2 heavy-duty, sling/solid seat/back, patient weight capacity 301 to 450 pounds | History and physical to Include the following: diagnosis; abilities and limitations as they relate to the equipment (e.g., degree of independence/ dependence, frequency and nature of the activities the patient performs), duration of medical condition, Past experience if any using similar equipment, evaluation of upper extremity strength. |
| K0825 | Power wheelchair, group 2 heavy-duty, captain's chair, patient weight capacity 301 to 450 pounds | History and physical to Include the following: diagnosis; abilities and limitations as they relate to the equipment (e.g., degree of independence/ dependence, frequency and nature of the activities the patient performs), duration of medical condition, Past experience if any using similar equipment, evaluation of upper extremity strength. |
| K0826 | Power wheelchair, group 2 very heavy-duty, sling/solid seat/back, patient weight capacity 451 to 600 pounds | History and physical to Include the following: diagnosis; abilities and limitations as they relate to the equipment (e.g., degree of independence/ dependence, frequency and nature of the activities the patient performs), duration of medical condition, Past experience if any using similar equipment, evaluation of upper extremity strength. |

| CPT and HCPCS Codes That May Require Prior Authorization | Description of Procedure Code | Medical Records Request Information Required |
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| K0827 | Power wheelchair, group 2 very heavy-duty, captain's chair, patient weight capacity 451 to 600 pounds | History and physical to Include the following: diagnosis; abilities and limitations as they relate to the equipment (e.g., degree of independence/ dependence, frequency and nature of the activities the patient performs), duration of medical condition, Past experience if any using similar equipment, evaluation of upper extremity strength. |
| K0828 | Power wheelchair, group 2 extra heavy-duty, sling/solid seat/back, patient weight capacity 601 pounds or more | History and physical to Include the following: diagnosis; abilities and limitations as they relate to the equipment (e.g., degree of independence/ dependence, frequency and nature of the activities the patient performs), duration of medical condition, Past experience if any using similar equipment, evaluation of upper extremity strength. |
| K0829 | Power wheelchair, group 2 extra heavy-duty, captain's chair, patient weight 601 pounds or more | History and physical to Include the following: diagnosis; abilities and limitations as they relate to the equipment (e.g., degree of independence/ dependence, frequency and nature of the activities the patient performs), duration of medical condition, Past experience if any using similar equipment, evaluation of upper extremity strength. |
| K0830 | Power wheelchair, group 2 standard, seat elevator, sling/solid seat/back, patient weight capacity up to and including 300 pounds | History and physical to Include the following: diagnosis; abilities and limitations as they relate to the equipment (e.g., degree of independence/ dependence, frequency and nature of the activities the patient performs), duration of medical condition, Past experience if any using similar equipment, evaluation of upper extremity strength. |
| K0831 | Power wheelchair, group 2 standard, seat elevator, captain's chair, patient weight capacity up to and including 300 pounds | History and physical to Include the following: diagnosis; abilities and limitations as they relate to the equipment (e.g., degree of independence/ dependence, frequency and nature of the activities the patient performs), duration of medical condition, Past experience if any using similar equipment, evaluation of upper extremity strength. |
| K0835 | POWER WHEELCHAIR, GROUP 2 STANDARD, SINGLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS | History and physical to Include the following: diagnosis; abilities and limitations as they relate to the equipment (e.g., degree of independence/ dependence, frequency and nature of the activities the patient performs), duration of medical condition, Past experience if any using similar equipment, evaluation of upper extremity strength. |

| CPT and HCPCS Codes That May Require Prior Authorization | Description of Procedure Code | Medical Records Request Information Required |
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| K0836 | Power wheelchair, group 2 standard, single power option, captain's chair, patient weight capacity up to and including 300 pounds | History and physical to Include the following: diagnosis; abilities and limitations as they relate to the equipment (e.g., degree of independence/ dependence, frequency and nature of the activities the patient performs), duration of medical condition, Past experience if any using similar equipment, evaluation of upper extremity strength. |
| K0837 | Power wheelchair, group 2 heavy-duty, single power option, sling/solid seat/back, patient weight capacity 301 to 450 pounds | History and physical to Include the following: diagnosis; abilities and limitations as they relate to the equipment (e.g., degree of independence/ dependence, frequency and nature of the activities the patient performs), duration of medical condition, Past experience if any using similar equipment, evaluation of upper extremity strength. |
| K0838 | Power wheelchair, group 2 heavy-duty, single power option, captain's chair, patient weight capacity 301 to 450 pounds | History and physical to Include the following: diagnosis; abilities and limitations as they relate to the equipment (e.g., degree of independence/ dependence, frequency and nature of the activities the patient performs), duration of medical condition, Past experience if any using similar equipment, evaluation of upper extremity strength. |
| K0839 | Power wheelchair, group 2 very heavy-duty, single power option sling/solid seat/back, patient weight capacity 451 to 600 pounds | History and physical to Include the following: diagnosis; abilities and limitations as they relate to the equipment (e.g., degree of independence/ dependence, frequency and nature of the activities the patient performs), duration of medical condition, Past experience if any using similar equipment, evaluation of upper extremity strength. |
| K0840 | Power wheelchair, group 2 extra heavy-duty, single power option, sling/solid seat/back, patient weight capacity 601 pounds or more | History and physical to Include the following: diagnosis; abilities and limitations as they relate to the equipment (e.g., degree of independence/ dependence, frequency and nature of the activities the patient performs), duration of medical condition, Past experience if any using similar equipment, evaluation of upper extremity strength. |
| K0841 | Power wheelchair, group 2 standard, multiple power option, sling/solid seat/back, patient weight capacity up to and including 300 pounds | History and physical to Include the following: diagnosis; abilities and limitations as they relate to the equipment (e.g., degree of independence/ dependence, frequency and nature of the activities the patient performs), duration of medical condition, Past experience if any using similar equipment, evaluation of upper extremity strength. |

| CPT and HCPCS Codes That May Require Prior Authorization | Description of Procedure Code | Medical Records Request Information Required |
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| K0842 | Power wheelchair, group 2 standard, multiple power option, captain's chair, patient weight capacity up to and including 300 pounds | History and physical to Include the following: diagnosis; abilities and limitations as they relate to the equipment (e.g., degree of independence/ dependence, frequency and nature of the activities the patient performs), duration of medical condition, Past experience if any using similar equipment, evaluation of upper extremity strength. |
| K0843 | Power wheelchair, group 2 heavy-duty, multiple power option, sling/solid seat/back, patient weight capacity 301 to 450 pounds | History and physical to Include the following: diagnosis; abilities and limitations as they relate to the equipment (e.g., degree of independence/ dependence, frequency and nature of the activities the patient performs), duration of medical condition, Past experience if any using similar equipment, evaluation of upper extremity strength. |
| K0848 | POWER WHEELCHAIR, GROUP 3 STANDARD, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS | History and physical to Include the following: diagnosis; abilities and limitations as they relate to the equipment (e.g., degree of independence/ dependence, frequency and nature of the activities the patient performs), duration of medical condition, Past experience if any using similar equipment, evaluation of upper extremity strength. |
| K0849 | Power wheelchair, group 3 standard, captains chair, patient weight capacity up to and including 300 pounds | History and physical to Include the following: diagnosis; abilities and limitations as they relate to the equipment (e.g., degree of independence/ dependence, frequency and nature of the activities the patient performs), duration of medical condition, Past experience if any using similar equipment, evaluation of upper extremity strength. |
| K0850 | Power wheelchair, group 3 heavy-duty, sling/solid seat/back, patient weight capacity 301 to 450 pounds | History and physical to Include the following: diagnosis; abilities and limitations as they relate to the equipment (e.g., degree of independence/ dependence, frequency and nature of the activities the patient performs), duration of medical condition, Past experience if any using similar equipment, evaluation of upper extremity strength. |
| K0851 | Power wheelchair, group 3 heavy-duty, captain's chair, patient weight capacity 301 to 450 pounds | History and physical to Include the following: diagnosis; abilities and limitations as they relate to the equipment (e.g., degree of independence/ dependence, frequency and nature of the activities the patient performs), duration of medical condition, Past experience if any using similar equipment, evaluation of upper extremity strength. |

| CPT and HCPCS Codes That May Require Prior Authorization | Description of Procedure Code | Medical Records Request Information Required |
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| K0852 | Power wheelchair, group 3 very heavy-duty, sling/solid seat/back, patient weight capacity 451 to 600 pounds | History and physical to Include the following: diagnosis; abilities and limitations as they relate to the equipment (e.g., degree of independence/ dependence, frequency and nature of the activities the patient performs), duration of medical condition, Past experience if any using similar equipment, evaluation of upper extremity strength. |
| K0853 | Power wheelchair, group 3 very heavy-duty, captain's chair, patient weight capacity 451 to 600 pounds | History and physical to Include the following: diagnosis; abilities and limitations as they relate to the equipment (e.g., degree of independence/ dependence, frequency and nature of the activities the patient performs), duration of medical condition, Past experience if any using similar equipment, evaluation of upper extremity strength. |
| K0854 | Power wheelchair, group 3 extra heavy-duty, sling/solid seat/back, patient weight capacity 601 pounds or more | History and physical to Include the following: diagnosis; abilities and limitations as they relate to the equipment (e.g., degree of independence/ dependence, frequency and nature of the activities the patient performs), duration of medical condition, Past experience if any using similar equipment, evaluation of upper extremity strength. |
| K0855 | Power wheelchair, group 3 extra heavy-duty, captain's chair, patient weight capacity 601 pounds or more | History and physical to Include the following: diagnosis; abilities and limitations as they relate to the equipment (e.g., degree of independence/ dependence, frequency and nature of the activities the patient performs), duration of medical condition, Past experience if any using similar equipment, evaluation of upper extremity strength. |
| K0856 | POWER WHEELCHAIR, GROUP 3 STANDARD, SINGLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS | History and physical to Include the following: diagnosis; abilities and limitations as they relate to the equipment (e.g., degree of independence/ dependence, frequency and nature of the activities the patient performs), duration of medical condition, Past experience if any using similar equipment, evaluation of upper extremity strength. |
| K0856 | Power wheelchair, group 3 standard, single power option, sling/solid seat/back, patient weight capacity up to and including 300 pounds | History and physical to Include the following: diagnosis; abilities and limitations as they relate to the equipment (e.g., degree of independence/ dependence, frequency and nature of the activities the patient performs), duration of medical condition, Past experience if any using similar equipment, evaluation of upper extremity strength. |

| CPT and HCPCS Codes That May Require Prior Authorization | Description of Procedure Code | Medical Records Request Information Required |
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| K0857 | Power wheelchair, group 3 standard, single power option, captain's chair, patient weight capacity up to and including 300 pounds | History and physical to Include the following: diagnosis; abilities and limitations as they relate to the equipment (e.g., degree of independence/ dependence, frequency and nature of the activities the patient performs), duration of medical condition, Past experience if any using similar equipment, evaluation of upper extremity strength. |
| K0858 | Power wheelchair, group 3 heavy-duty, single power option, sling/solid seat/back, patient weight 301 to 450 pounds | History and physical to Include the following: diagnosis; abilities and limitations as they relate to the equipment (e.g., degree of independence/ dependence, frequency and nature of the activities the patient performs), duration of medical condition, Past experience if any using similar equipment, evaluation of upper extremity strength. |
| K0859 | Power wheelchair, group 3 heavy-duty, single power option, captain's chair, patient weight capacity 301 to 450 pounds | History and physical to Include the following: diagnosis; abilities and limitations as they relate to the equipment (e.g., degree of independence/ dependence, frequency and nature of the activities the patient performs), duration of medical condition, Past experience if any using similar equipment, evaluation of upper extremity strength. |
| K0860 | Power wheelchair, group 3 very heavy-duty, single power option, sling/solid seat/back, patient weight capacity 451 to 600 pounds | History and physical to Include the following: diagnosis; abilities and limitations as they relate to the equipment (e.g., degree of independence/ dependence, frequency and nature of the activities the patient performs), duration of medical condition, Past experience if any using similar equipment, evaluation of upper extremity strength. |
| K0861 | POWER WHEELCHAIR, GROUP 3 STANDARD, MULTIPLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS | History and physical to Include the following: diagnosis; abilities and limitations as they relate to the equipment (e.g., degree of independence/ dependence, frequency and nature of the activities the patient performs), duration of medical condition, Past experience if any using similar equipment, evaluation of upper extremity strength. |
| K0862 | POWER WHEELCHAIR, GROUP 3 HEAVY DUTY, MULTIPLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS | History and physical to Include the following: diagnosis; abilities and limitations as they relate to the equipment (e.g., degree of independence/ dependence, frequency and nature of the activities the patient performs), duration of medical condition, Past experience if any using similar equipment, evaluation of upper extremity strength. |

| CPT and HCPCS Codes That May Require Prior Authorization | Description of Procedure Code | Medical Records Request Information Required |
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| K0863 | Power wheelchair, group 3 very heavy-duty, multiple power option, sling/solid seat/back, patient weight capacity 451 to 600 pounds | History and physical to Include the following: diagnosis; abilities and limitations as they relate to the equipment (e.g., degree of independence/ dependence, frequency and nature of the activities the patient performs), duration of medical condition, Past experience if any using similar equipment, evaluation of upper extremity strength. |
| K0864 | Power wheelchair, group 3 extra heavy-duty, multiple power option, sling/solid seat/back, patient weight capacity 601 pounds or more | History and physical to Include the following: diagnosis; abilities and limitations as they relate to the equipment (e.g., degree of independence/ dependence, frequency and nature of the activities the patient performs), duration of medical condition, Past experience if any using similar equipment, evaluation of upper extremity strength. |
| K0868 | POWER WHEELCHAIR, GROUP 4 STANDARD, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS | History and physical to Include the following: diagnosis; abilities and limitations as they relate to the equipment (e.g., degree of independence/ dependence, frequency and nature of the activities the patient performs), duration of medical condition, Past experience if any using similar equipment, evaluation of upper extremity strength. |
| K0869 | Power wheelchair, group 4 standard, captain's chair, patient weight capacity up to and including 300 pounds | History and physical to Include the following: diagnosis; abilities and limitations as they relate to the equipment (e.g., degree of independence/ dependence, frequency and nature of the activities the patient performs), duration of medical condition, Past experience if any using similar equipment, evaluation of upper extremity strength. |
| K0870 | Power wheelchair, group 4 heavy-duty, sling/solid seat/back, patient weight capacity 301 to 450 pounds | History and physical to Include the following: diagnosis; abilities and limitations as they relate to the equipment (e.g., degree of independence/ dependence, frequency and nature of the activities the patient performs), duration of medical condition, Past experience if any using similar equipment, evaluation of upper extremity strength. |
| K0871 | Power wheelchair, group 4 very heavy-duty, sling/solid seat/back, patient weight capacity 451 to 600 pounds | History and physical to Include the following: diagnosis; abilities and limitations as they relate to the equipment (e.g., degree of independence/ dependence, frequency and nature of the activities the patient performs), duration of medical condition, Past experience if any using similar equipment, evaluation of upper extremity strength. |

| CPT and HCPCS Codes That May Require Prior Authorization | Description of Procedure Code | Medical Records Request Information Required |
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| K0877 | Power wheelchair, group 4 standard, single power option, sling/solid seat/back, patient weight capacity up to and including 300 pounds | History and physical to Include the following: diagnosis; abilities and limitations as they relate to the equipment (e.g., degree of independence/ dependence, frequency and nature of the activities the patient performs), duration of medical condition, Past experience if any using similar equipment, evaluation of upper extremity strength. |
| K0878 | Power wheelchair, group 4 standard, single power option, captain's chair, patient weight capacity up to and including 300 pounds | History and physical to Include the following: diagnosis; abilities and limitations as they relate to the equipment (e.g., degree of independence/ dependence, frequency and nature of the activities the patient performs), duration of medical condition, Past experience if any using similar equipment, evaluation of upper extremity strength. |
| K0879 | Power wheelchair, group 4 heavy-duty, single power option, sling/solid seat/back, patient weight capacity 301 to 450 pounds | History and physical or clinical notes, including anticipated length of use. |
| K0880 | Power wheelchair, group 4 very heavy-duty, single power option, sling/solid seat/back, patient weight 451 to 600 pounds | History and physical or clinical notes, including anticipated length of use. |
| K0884 | POWER WHEELCHAIR, GROUP 4 STANDARD, MULTIPLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS | History and physical to Include the following: diagnosis; abilities and limitations as they relate to the equipment (e.g., degree of independence/ dependence, frequency and nature of the activities the patient performs), duration of medical condition, Past experience if any using similar equipment, evaluation of upper extremity strength. |
| K0885 | Power wheelchair, group 4 standard, multiple power option, captain's chair, patient weight capacity up to and including 300 pounds | History and physical to Include the following: diagnosis; abilities and limitations as they relate to the equipment (e.g., degree of independence/ dependence, frequency and nature of the activities the patient performs), duration of medical condition, Past experience if any using similar equipment, evaluation of upper extremity strength. |
| K0886 | Power wheelchair, group 4 heavy-duty, multiple power option, sling/solid seat/back, patient weight capacity 301 to 450 pounds | History and physical to Include the following: diagnosis; abilities and limitations as they relate to the equipment (e.g., degree of independence/ dependence, frequency and nature of the activities the patient performs), duration of medical condition, Past experience if any using similar equipment, evaluation of upper extremity strength. |

| CPT and HCPCS Codes That May Require Prior Authorization | Description of Procedure Code | Medical Records Request Information Required |
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| K0890 | POWER WHEELCHAIR, GROUP 5 PEDIATRIC, SINGLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 125 POUNDS | History and physical to Include the following: diagnosis; abilities and limitations as they relate to the equipment (e.g., degree of independence/ dependence, frequency and nature of the activities the patient performs), duration of medical condition, Past experience if any using similar equipment, evaluation of upper extremity strength. |
| K0891 | Power wheelchair, group 5 pediatric, multiple power option, sling/solid seat/back, patient weight capacity up to and including 125 pounds | History and physical or clinical notes, including anticipated length of use. |
| K0898 | Power wheelchair, not otherwise classified | History and physical or clinical notes, including anticipated length of use. |
| K0899 | Power mobility device, not coded by DME PDAC or does not meet criteria | History and physical or clinical notes, including anticipated length of use. |
| L0456 | Tlso, flexible, provides trunk support, thoracic region, rigid posterior panel and soft anterior apron, extends from the sacrococcygeal junction and terminates just inferior to the scapular spine, restricts gross trunk motion in the sagittal plane, produces intracavitary pressure to reduce load on the intervertebral disks, includes straps and closures, prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L0458 | Thoracic-lumbar-sacral orthotic (TLSO), triplanar control, modular segmented spinal system, 2 rigid plastic shells, posterior extends from the sacrococcygeal junction and terminates just inferior to the scapular spine, anterior extends from the symphysis pubis to the xiphoid, soft liner, restricts gross trunk motion in the sagittal, coronal, and transverse planes, lateral strength is provided by overlapping plastic and stabilizing closures, includes straps and closures, prefabricated, includes fitting and adjustment | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |

| CPT and HCPCS Codes That May Require Prior Authorization | Description of Procedure Code | Medical Records Request Information Required |
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| L0460 | <p>TLSO, triplanar control, modular segmented spinal system, two rigid plastic shells, posterior extends from the sacrococcygeal junction and terminates just inferior to the scapular spine, anterior extends from the symphysis pubis to the sternal notch, soft liner, restricts gross trunk motion in the sagittal, coronal, and transverse planes, lateral strength is provided by overlapping plastic and stabilizing closures, includes straps and closures, prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise</p> | <p>Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition.</p> |
| L0462 | <p>Thoracic-lumbar-sacral orthotic (TLSO), triplanar control, modular segmented spinal system, 3 rigid plastic shells, posterior extends from the sacrococcygeal junction and terminates just inferior to the scapular spine, anterior extends from the symphysis pubis to the sternal notch, soft liner, restricts gross trunk motion in the sagittal, coronal, and transverse planes, lateral strength is provided by overlapping plastic and stabilizing closures, includes straps and closures, prefabricated, includes fitting and adjustment</p> | <p>Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition.</p> |

| CPT and HCPCS Codes That May Require Prior Authorization | Description of Procedure Code | Medical Records Request Information Required |
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| L0464 | Thoracic-lumbar-sacral orthotic (TLSO), triplanar control, modular segmented spinal system, 4 rigid plastic shells, posterior extends from sacrococcygeal junction and terminates just inferior to scapular spine, anterior extends from symphysis pubis to the sternal notch, soft liner, restricts gross trunk motion in sagittal, coronal, and transverse planes, lateral strength is provided by overlapping plastic and stabilizing closures, includes straps and closures, prefabricated, includes fitting and adjustment | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L0480 | Thoracic-lumbar-sacral orthotic (TLSO), triplanar control, 1 piece rigid plastic shell without interface liner, with multiple straps and closures, posterior extends from sacrococcygeal junction and terminates just inferior to scapular spine, anterior extends from symphysis pubis to sternal notch, anterior or posterior opening, restricts gross trunk motion in sagittal, coronal, and transverse planes, includes a carved plaster or CAD-CAM model, custom fabricated | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L0482 | Tlso, triplanar control, one piece rigid plastic shell with interface liner, multiple straps and closures, posterior extends from sacrococcygeal junction and terminates just inferior to scapular spine, anterior extends from symphysis pubis to sternal notch, anterior or posterior opening, restricts gross trunk motion in sagittal, coronal, and transverse planes, includes a carved plaster or cad-cam model, custom fabricated | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |

| CPT and HCPCS Codes That May Require Prior Authorization | Description of Procedure Code | Medical Records Request Information Required |
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| L0484 | Thoracic-lumbar-sacral orthotic (TLSO), triplanar control, 2 piece rigid plastic shell without interface liner, with multiple straps and closures, posterior extends from sacrococcygeal junction and terminates just inferior to scapular spine, anterior extends from symphysis pubis to sternal notch, lateral strength is enhanced by overlapping plastic, restricts gross trunk motion in the sagittal, coronal, and transverse planes, includes a carved plaster or CAD-CAM model, custom fabricated | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L0486 | Tlso, triplanar control, two piece rigid plastic shell with interface liner, multiple straps and closures, posterior extends from sacrococcygeal junction and terminates just inferior to scapular spine, anterior extends from symphysis pubis to sternal notch, lateral strength is enhanced by overlapping plastic, restricts gross trunk motion in the sagittal, coronal, and transverse planes, includes a carved plaster or cad-cam model, custom fabricated | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L0631 | Lumbar-sacral orthosis, sagittal control, with rigid anterior and posterior panels, posterior extends from sacrococcygeal junction to t-9 vertebra, produces intracavitary pressure to reduce load on the intervertebral discs, includes straps, closures, may include padding, shoulder straps, pendulous abdomen design, prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |

| CPT and HCPCS Codes That May Require Prior Authorization | Description of Procedure Code | Medical Records Request Information Required |
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| L0637 | Lumbar-sacral orthosis, sagittal-coronal control, with rigid anterior and posterior frame/panels, posterior extends from sacrococcygeal junction to t-9 vertebra, lateral strength provided by rigid lateral frame/panels, produces intracavitary pressure to reduce load on intervertebral discs, includes straps, closures, may include padding, shoulder straps, pendulous abdomen design, prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L0638 | Lumbar-sacral orthotic (LSO), sagittal-coronal control, with rigid anterior and posterior frame/panels, posterior extends from sacrococcygeal junction to T-9 vertebra, lateral strength provided by rigid lateral frame/panels, produces intracavitary pressure to reduce load on intervertebral discs, includes straps, closures, may include padding, shoulder straps, pendulous abdomen design, custom fabricated | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L0639 | Lumbar-sacral orthosis, sagittal-coronal control, rigid shell(s)/panel(s), posterior extends from sacrococcygeal junction to T-9 vertebra, anterior extends from symphysis pubis to xyphoid, produces intracavitary pressure to reduce load on the intervertebral discs, overall strength is provided by overlapping rigid material and stabilizing closures, includes straps, closures, may include soft interface, pendulous abdomen design, prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |

| CPT and HCPCS Codes That May Require Prior Authorization | Description of Procedure Code | Medical Records Request Information Required |
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| L0640 | Lumbar-sacral orthotic (LSO), sagittal-coronal control, rigid shell(s)/panel(s), posterior extends from sacrococcygeal junction to T-9 vertebra, anterior extends from symphysis pubis to xyphoid, produces intracavitary pressure to reduce load on the intervertebral discs, overall strength is provided by overlapping rigid material and stabilizing closures, includes straps, closures, may include soft interface, pendulous abdomen design, custom fabricated | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L0700 | Cervical-thoracic-lumbar-sacral orthotic (CTLSO), anterior-posterior-lateral control, molded to patient model, (Minerva type) | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L0710 | Cervical-thoracic-lumbar-sacral orthotic (CTLSO), anterior-posterior-lateral-control, molded to patient model, with interface material, (Minerva type) | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L0810 | Halo procedure, cervical halo incorporated into jacket vest | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L0820 | Halo procedure, cervical halo incorporated into plaster body jacket | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L0830 | Halo procedure, cervical halo incorporated into Milwaukee type orthotic | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L0859 | Addition to halo procedure, magnetic resonance image compatible systems, rings and pins, any material | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L1000 | Cervical-thoracic-lumbar-sacral orthotic (CTLSO) (Milwaukee), inclusive of furnishing initial orthotic, including model | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L1005 | Tension based scoliosis orthosis and accessory pads, includes fitting and adjustment | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L1200 | Thoracic-lumbar-sacral orthotic (TLSO), inclusive of furnishing initial orthotic only | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |

| CPT and HCPCS Codes That May Require Prior Authorization | Description of Procedure Code | Medical Records Request Information Required |
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| L1300 | Other scoliosis procedure, body jacket molded to patient model | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L1310 | Other scoliosis procedure, postoperative body jacket | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L1499 | Spinal orthotic, not otherwise specified | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L1680 | Hip orthotic (HO), abduction control of hip joints, dynamic, pelvic control, adjustable hip motion control, thigh cuffs (Rancho hip action type), custom fabricated | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L1685 | Hip orthosis (HO), abduction control of hip joint, postoperative hip abduction type, custom fabricated | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L1686 | Hip orthosis, abduction control of hip joint, postoperative hip abduction type, prefabricated, includes fitting and adjustment | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L1690 | Combination, bilateral, lumbo-sacral, hip, femur orthosis providing adduction and internal rotation control, prefabricated, includes fitting and adjustment | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L1700 | Legg Perthes orthotic, (Toronto type), custom fabricated | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L1710 | Legg Perthes orthotic, (Newington type), custom fabricated | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L1720 | Legg Perthes orthotic, trilateral, (Tachdijan type), custom fabricated | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L1730 | Legg Perthes orthotic, (Scottish Rite type), custom fabricated | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L1755 | Legg Perthes orthotic, (Patten bottom type), custom fabricated | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |

| CPT and HCPCS Codes That May Require Prior Authorization | Description of Procedure Code | Medical Records Request Information Required |
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| L1843 | Knee orthosis, single upright, thigh and calf, with adjustable flexion and extension joint (unicentric or polycentric), medial-lateral and rotation control, with or without varus/valgus adjustment, prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L1844 | Knee orthosis, single upright, thigh and calf, with adjustable flexion and extension joint (unicentric or polycentric), medial-lateral and rotation control, with or without varus/valgus adjustment, custom fabricated | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L1845 | Knee orthosis, double upright, thigh and calf, with adjustable flexion and extension joint (unicentric or polycentric), medial-lateral and rotation control, with or without varus/valgus adjustment, prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L1846 | KNEE ORTHOSIS, DOUBLE UPRIGHT, THIGH AND CALF, WITH ADJUSTABLE FLEXION AND EXTENSION JOINT (UNICENTRIC OR POLYCENTRIC), MEDIAL-LATERAL AND ROTATION CONTROL, WITH OR WITHOUT VARUS/VALGUS ADJUSTMENT, CUSTOM FABRICATED | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L1932 | Afo, rigid anterior tibial section, total carbon fiber or equal material, prefabricated, includes fitting and adjustment | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L1945 | Ankle foot orthosis, plastic, rigid anterior tibial section (floor reaction), custom fabricated | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L1950 | Ankle-foot orthotic (AFO), spiral, (Institute of Rehabilitative Medicine type), plastic, custom fabricated | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |

| CPT and HCPCS Codes That May Require Prior Authorization | Description of Procedure Code | Medical Records Request Information Required |
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| L1951 | Ankle foot orthosis, spiral, (institute of rehabilitative medicine type), plastic or other material, prefabricated, includes fitting and adjustment | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L2000 | Knee-ankle-foot orthotic (KAFO), single upright, free knee, free ankle, solid stirrup, thigh and calf bands/cuffs (single bar 'AK' orthotic), custom fabricated | History and physical or clinical notes, including anticipated length of use. |
| L2005 | Knee ankle foot orthosis, any material, single or double upright, stance control, automatic lock and swing phase release, any type activation, includes ankle joint, any type, custom fabricated | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L2020 | Knee ankle foot orthosis, double upright, free ankle, solid stirrup, thigh and calf bands/cuffs (double bar 'ak' orthosis), custom fabricated | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L2030 | Knee-ankle-foot orthotic (KAFO), double upright, free ankle, solid stirrup, thigh and calf bands/cuffs, (double bar 'AK' orthotic), without knee joint, custom fabricated | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L2034 | Knee ankle foot orthosis, full plastic, single upright, with or without free motion knee, medial lateral rotation control, with or without free motion ankle, custom fabricated | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L2036 | Knee ankle foot orthosis, full plastic, double upright, with or without free motion knee, with or without free motion ankle, custom fabricated | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L2037 | Knee-ankle-foot orthotic (KAFO), full plastic, single upright, with or without free motion knee, with or without free motion ankle, custom fabricated | History and physical or clinical notes, including anticipated length of use. |
| L2038 | Knee ankle foot orthosis, full plastic, with or without free motion knee, multi-axis ankle, custom fabricated | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L2108 | Ankle foot orthosis, fracture orthosis, tibial fracture cast orthosis, custom fabricated | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |

| CPT and HCPCS Codes That May Require Prior Authorization | Description of Procedure Code | Medical Records Request Information Required |
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| L2116 | Ankle foot orthosis, fracture orthosis, tibial fracture orthosis, rigid, prefabricated, includes fitting and adjustment | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L2232 | Addition to lower extremity orthosis, rocker bottom for total contact ankle foot orthosis, for custom fabricated orthosis only | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L2270 | Addition to lower extremity, varus/valgus correction ('t') strap, padded/lined or malleolus pad | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L2330 | Addition to lower extremity, lacer molded to patient model, for custom fabricated orthosis only | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L2340 | Addition to lower extremity, pre-tibial shell, molded to patient model | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L2350 | Addition to lower extremity, prosthetic type, (bk) socket, molded to patient model, (used for 'ptb' 'afo' orthoses) | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L2360 | Addition to lower extremity, extended steel shank | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L2385 | Addition to lower extremity, straight knee joint, heavy duty, each joint | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L2390 | Addition to lower extremity, offset knee joint, each joint | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L2395 | Addition to lower extremity, offset knee joint, heavy duty, each joint | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L2397 | Addition to lower extremity orthosis, suspension sleeve | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L2405 | Addition to knee joint, drop lock, each | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L2425 | Addition to knee joint, disc or dial lock for adjustable knee flexion, each joint | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L2624 | Addition to lower extremity, pelvic control, hip joint, adjustable flexion, extension, abduction control, each | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |

| CPT and HCPCS Codes That May Require Prior Authorization | Description of Procedure Code | Medical Records Request Information Required |
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| L2628 | Addition to lower extremity, pelvic control, metal frame, reciprocating hip joint and cables | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L2650 | Addition to lower extremity, pelvic and thoracic control, gluteal pad, each | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L2755 | Addition to lower extremity orthosis, high strength, lightweight material, all hybrid lamination/prepreg composite, per segment, for custom fabricated orthosis only | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L2768 | Orthotic side bar disconnect device, per bar | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L2780 | Addition to lower extremity orthosis, non-corrosive finish, per bar | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L2785 | Addition to lower extremity orthosis, drop lock retainer, each | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L2795 | Addition to lower extremity orthosis, knee control, full kneecap | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L2800 | Addition to lower extremity orthosis, knee control, knee cap, medial or lateral pull, for use with custom fabricated orthosis only | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L2810 | Addition to lower extremity orthosis, knee control, condylar pad | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L2830 | Addition to lower extremity orthosis, soft interface for molded plastic, above knee section | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L2840 | Addition to lower extremity orthosis, tibial length sock, fracture or equal, each | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L2861 | Addition to lower extremity joint, knee or ankle, concentric adjustable torsion style mechanism for custom fabricated orthotics only, each | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L2999 | Lower extremity orthoses, not otherwise specified | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |

| CPT and HCPCS Codes That May Require Prior Authorization | Description of Procedure Code | Medical Records Request Information Required |
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| L3031 | Foot, insert/plate, removable, addition to lower extremity orthosis, high strength, lightweight material, all hybrid lamination/prepreg composite, each | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L3702 | Elbow orthosis, without joints, may include soft interface, straps, custom fabricated, includes fitting and adjustment | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L3720 | Elbow orthosis, double upright with forearm/arm cuffs, free motion, custom fabricated | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L3740 | Elbow orthotic (EO), double upright with forearm/arm cuffs, adjustable position lock with active control, custom fabricated | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L3765 | Elbow-wrist-hand-finger orthotic (EWHFO), rigid, without joints, may include soft interface, straps, custom fabricated, includes fitting and adjustment | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L3766 | Elbow-wrist-hand-finger orthotic (EWHFO), includes one or more nontorsion joints, elastic bands, turnbuckles, may include soft interface, straps, custom fabricated, includes fitting and adjustment | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L3808 | Wrist hand finger orthosis, rigid without joints, may include soft interface material; straps, custom fabricated, includes fitting and adjustment | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L3891 | Addition to upper extremity joint, wrist or elbow, concentric adjustable torsion style mechanism for custom fabricated orthotics only, each | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L3900 | Wrist-hand-finger orthotic (WHFO), dynamic flexor hinge, reciprocal wrist extension/flexion, finger flexion/extension, wrist or finger driven, custom fabricated | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L3901 | Wrist-hand-finger orthotic (WHFO), dynamic flexor hinge, reciprocal wrist extension/flexion, finger flexion/extension, cable driven, custom fabricated | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |

| CPT and HCPCS Codes That May Require Prior Authorization | Description of Procedure Code | Medical Records Request Information Required |
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| L3904 | Wrist hand finger orthosis, external powered, electric, custom fabricated | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L3919 | Hand orthosis, without joints, may include soft interface, straps, custom fabricated, includes fitting and adjustment | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L3961 | Shoulder elbow wrist hand orthotic (SEWHO), shoulder cap design, without joints, may include soft interface, straps, custom fabricated, includes fitting and adjustment | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L3962 | Shoulder-elbow-wrist-hand orthotic (SEWHO), abduction positioning, Erb's palsy design, prefabricated, includes fitting and adjustment | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L3967 | Shoulder-elbow-wrist-hand orthotic (SEWHO), abduction positioning (airplane design), thoracic component and support bar, without joints, may include soft interface, straps, custom fabricated, includes fitting and adjustment | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L3971 | Shoulder-elbow-wrist-hand orthotic (SEWHO), shoulder cap design, includes one or more nontorsion joints, elastic bands, turnbuckles, may include soft interface, straps, custom fabricated, includes fitting and adjustment | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L3973 | Shoulder-elbow-wrist-hand orthotic (SEWHO), abduction positioning (airplane design), thoracic component and support bar, includes one or more nontorsion joints, elastic bands, turnbuckles, may include soft interface, straps, custom fabricated, includes fitting and adjustment | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L3975 | Shoulder-elbow-wrist-hand-finger orthotic (SEWHO), shoulder cap design, without joints, may include soft interface, straps, custom fabricated, includes fitting and adjustment | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |

| CPT and HCPCS Codes That May Require Prior Authorization | Description of Procedure Code | Medical Records Request Information Required |
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| L3976 | Shoulder-elbow-wrist-hand-finger orthotic (SEWHO), abduction positioning (airplane design), thoracic component and support bar, without joints, may include soft interface, straps, custom fabricated, includes fitting and adjustment | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L3977 | Shoulder-elbow-wrist-hand-finger orthotic (SEWHO), shoulder cap design, includes one or more nontorsion joints, elastic bands, turnbuckles, may include soft interface, straps, custom fabricated, includes fitting and adjustment | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L3978 | Shoulder-elbow-wrist-hand-finger orthotic (SEWHO), abduction positioning (airplane design), thoracic component and support bar, includes one or more nontorsion joints, elastic bands, turnbuckles, may include soft interface, straps, custom fabricated, includes fitting and adjustment | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L3995 | Addition to upper extremity orthosis, sock, fracture or equal, each | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L3999 | UPPER LIMB ORTHOSIS, NOT OTHERWISE SPECIFIED | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L4000 | Replace girdle for spinal orthotic (cervical-thoracic-lumbar-sacral orthotic (CTLSO) or spinal orthotic SO | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L4002 | Replacement strap, any orthosis, includes all components, any length, any type | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L4205 | Repair of orthotic device, labor component, per 15 minutes | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L4396 | Static or dynamic ankle foot orthosis, including soft interface material, adjustable for fit, for positioning, may be used for minimal ambulation, prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |

| CPT and HCPCS Codes That May Require Prior Authorization | Description of Procedure Code | Medical Records Request Information Required |
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| L4631 | Ankle foot orthosis, walking boot type, varus/valgus correction, rocker bottom, anterior tibial shell, soft interface, custom arch support, plastic or other material, includes straps and closures, custom fabricated | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L5010 | Partial foot, molded socket, ankle height, with toe filler | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L5020 | Partial foot, molded socket, tibial tubercle height, with toe filler | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L5050 | Ankle, Symes, molded socket, SACH foot | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L5060 | Ankle, Symes, metal frame, molded leather socket, articulated ankle/foot | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L5100 | Below knee, molded socket, shin, sach foot | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L5105 | Below knee, plastic socket, joints and thigh lacer, sach foot | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L5150 | Knee disarticulation (or through knee), molded socket, external knee joints, shin, sach foot | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L5160 | Knee disarticulation (or through knee), molded socket, bent knee configuration, external knee joints, shin, sach foot | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L5200 | Above knee, molded socket, single axis constant friction knee, shin, sach foot | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L5210 | Above knee, short prosthesis, no knee joint (stubbies), with foot blocks, no ankle joints, each | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L5220 | Above knee, short prosthesis, no knee joint (stubbies), with articulated ankle/foot, dynamically aligned, each | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L5230 | Above knee, for proximal femoral focal deficiency, constant friction knee, shin, sach foot | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |

| CPT and HCPCS Codes That May Require Prior Authorization | Description of Procedure Code | Medical Records Request Information Required |
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| L5250 | Hip disarticulation, canadian type; molded socket, hip joint, single axis constant friction knee, shin, sach foot | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L5270 | Hip disarticulation, tilt table type; molded socket, locking hip joint, single axis constant friction knee, shin, sach foot | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L5280 | Hemipelvectomy, canadian type; molded socket, hip joint, single axis constant friction knee, shin, sach foot | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L5301 | Below knee, molded socket, shin, sach foot, endoskeletal system | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L5312 | Knee disarticulation (or through knee), molded socket, single axis knee, pylon, sach foot, endoskeletal system | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L5321 | Above knee, molded socket, open end, sach foot, endoskeletal system, single axis knee | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L5331 | Hip disarticulation, canadian type, molded socket, endoskeletal system, hip joint, single axis knee, sach foot | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L5341 | Hemipelvectomy, canadian type, molded socket, endoskeletal system, hip joint, single axis knee, sach foot | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L5400 | Immediate postsurgical or early fitting, application of initial rigid dressing, including fitting, alignment, suspension, and one cast change, below knee | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L5420 | Immediate postsurgical or early fitting, application of initial rigid dressing, including fitting, alignment and suspension and one cast change AK or knee disarticulation | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L5500 | Initial, below knee 'ptb' type socket, non-alignable system, pylon, no cover, sach foot, plaster socket, direct formed | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L5505 | Initial, above knee, knee disarticulation, ischial level socket, nonalignable system, pylon, no cover, SACH foot, plaster socket, direct formed | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |

| CPT and HCPCS Codes That May Require Prior Authorization | Description of Procedure Code | Medical Records Request Information Required |
|--|---|--|
| L5510 | Preparatory, below knee PTB type socket, nonalignable system, pylon, no cover, SACH foot, plaster socket, molded to model | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L5520 | Preparatory, below knee PTB type socket, nonalignable system, pylon, no cover, SACH foot, thermoplastic or equal, direct formed | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L5530 | Preparatory, below knee 'ptb' type socket, non-alignable system, pylon, no cover, sach foot, thermoplastic or equal, molded to model | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L5535 | Preparatory, below knee PTB type socket, nonalignable system, no cover, SACH foot, prefabricated, adjustable open end socket | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L5540 | Preparatory, below knee 'ptb' type socket, non-alignable system, pylon, no cover, sach foot, laminated socket, molded to model | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L5560 | Preparatory, above knee, knee disarticulation, ischial level socket, nonalignable system, pylon, no cover, SACH foot, plaster socket, molded to model | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L5570 | Preparatory, above knee - knee disarticulation, ischial level socket, nonalignable system, pylon, no cover, SACH foot, thermoplastic or equal, direct formed | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L5580 | Preparatory, above knee - knee disarticulation ischial level socket, non-alignable system, pylon, no cover, sach foot, thermoplastic or equal, molded to model | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L5585 | Preparatory, above knee - knee disarticulation, ischial level socket, nonalignable system, pylon, no cover, SACH foot, prefabricated adjustable open end socket | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L5590 | Preparatory, above knee - knee disarticulation ischial level socket, non-alignable system, pylon no cover, sach foot, laminated socket, molded to model | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |

| CPT and HCPCS Codes That May Require Prior Authorization | Description of Procedure Code | Medical Records Request Information Required |
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| L5595 | Preparatory, hip disarticulation/hemipelvectomy, pylon, no cover, SACH foot, thermoplastic or equal, molded to patient model | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L5600 | Preparatory, hip disarticulation-hemipelvectomy, pylon, no cover, sach foot, laminated socket, molded to patient model | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L5610 | Addition to lower extremity, endoskeletal system, above knee, hydracadence system | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L5611 | Addition to lower extremity, endoskeletal system, above knee - knee disarticulation, 4 bar linkage, with friction swing phase control | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L5613 | Addition to lower extremity, endoskeletal system, above knee, knee disarticulation, 4-bar linkage, with hydraulic swing phase control | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L5614 | Addition to lower extremity, exoskeletal system, above knee-knee disarticulation, 4 bar linkage, with pneumatic swing phase control | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L5616 | Addition to lower extremity, endoskeletal system, above knee, universal multiplex system, friction swing phase control | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L5643 | Addition to lower extremity, hip disarticulation, flexible inner socket, external frame | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L5645 | Addition to lower extremity, below knee, flexible inner socket, external frame | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L5647 | Addition to lower extremity, below knee suction socket | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L5649 | Addition to lower extremity, ischial containment/narrow m-l socket | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L5651 | Addition to lower extremity, above knee, flexible inner socket, external frame | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |

| CPT and HCPCS Codes That May Require Prior Authorization | Description of Procedure Code | Medical Records Request Information Required |
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| L5700 | Replacement, socket, below knee, molded to patient model | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L5701 | Replacement, socket, above knee/knee disarticulation, including attachment plate, molded to patient model | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L5702 | Replacement, socket, hip disarticulation, including hip joint, molded to patient model | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L5703 | Ankle, Symes, molded to patient model, socket without solid ankle cushion heel (SACH) foot, replacement only | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L5707 | Custom shaped protective cover, hip disarticulation | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L5780 | Addition, exoskeletal knee-shin system, single axis, pneumatic/hydra pneumatic swing phase control | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L5781 | Addition to lower limb prosthesis, vacuum pump, residual limb volume management and moisture evacuation system | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L5782 | Addition to lower limb prosthesis, vacuum pump, residual limb volume management and moisture evacuation system, heavy duty | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L5814 | Addition, endoskeletal knee-shin system, polycentric, hydraulic swing phase control, mechanical stance phase lock | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L5826 | Addition, endoskeletal knee-shin system, single axis, hydraulic swing phase control, with miniature high activity frame | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L5828 | Addition, endoskeletal knee-shin system, single axis, fluid swing and stance phase control | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L5830 | Addition, endoskeletal knee-shin system, single axis, pneumatic/swing phase control | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L5840 | Addition, endoskeletal knee/shin system, 4-bar linkage or multiaxial, pneumatic swing phase control | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |

| CPT and HCPCS Codes That May Require Prior Authorization | Description of Procedure Code | Medical Records Request Information Required |
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| L5845 | Addition, endoskeletal, knee-shin system, stance flexion feature, adjustable | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L5856 | ADDITION TO LOWER EXTREMITY PROSTHESIS, ENDOSKELETAL KNEE-SHIN SYSTEM, MICROPROCESSOR CONTROL FEATURE, SWING AND STANCE PHASE, INCLUDES ELECTRONIC SENSOR(S), ANY TYPE | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L5857 | Addition to lower extremity prosthesis, endoskeletal knee-shin system, microprocessor control feature, swing phase only, includes electronic sensor(s), any type | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L5858 | Addition to lower extremity prosthesis, endoskeletal knee shin system, microprocessor control feature, stance phase only, includes electronic sensor(s), any type | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L5859 | Addition to lower extremity prosthesis, endoskeletal knee-shin system, powered and programmable flexion/extension assist control, includes any type motor(s) | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L5880 | Preparatory, above knee - knee disarticulation ischial level socket, non-alignable system, pylon, no cover, sach foot, thermoplastic or equal, molded to model | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L5910 | Addition, endoskeletal system, below knee, alignable system | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L5920 | Addition, endoskeletal system, above knee or hip disarticulation, alignable system | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L5930 | Addition, endoskeletal system, high activity knee control frame | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L5940 | Addition, endoskeletal system, below knee, ultra-light material (titanium, carbon fiber or equal) | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L5950 | Addition, endoskeletal system, above knee, ultra-light material (titanium, carbon fiber or equal) | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |

| CPT and HCPCS Codes That May Require Prior Authorization | Description of Procedure Code | Medical Records Request Information Required |
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| L5960 | Addition, endoskeletal system, hip disarticulation, ultra-light material (titanium, carbon fiber or equal) | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L5961 | Addition, endoskeletal system, polycentric hip joint, pneumatic or hydraulic control, rotation control, with or without flexion and/or extension control | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L5962 | Addition, endoskeletal system, below knee, flexible protective outer surface covering system | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L5964 | Addition, endoskeletal system, above knee, flexible protective outer surface covering system | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L5968 | Addition to lower limb prosthesis, multiaxial ankle with swing phase active dorsiflexion feature | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L5973 | Endoskeletal ankle foot system, microprocessor controlled feature, dorsiflexion and/or plantar flexion control, includes power source | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L5979 | All lower extremity prosthesis, multi-axial ankle, dynamic response foot, one piece system | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L5980 | All lower extremity prostheses, flex foot system | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L5981 | All lower extremity prostheses, flex-walk system or equal | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L5987 | All Lower Extremity Prosthesis, Shank Foot System With Vertical Loading Pylon | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L5988 | Addition to lower limb prosthesis, vertical shock reducing pylon feature | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L5990 | Addition to lower extremity prosthesis, user adjustable heel height | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L5999 | Lower extremity prosthesis, not otherwise specified | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |

| CPT and HCPCS Codes That May Require Prior Authorization | Description of Procedure Code | Medical Records Request Information Required |
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| L6000 | Partial hand, thumb remaining | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L6010 | Partial hand, little and/or ring finger remaining | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L6020 | Partial hand, no finger remaining | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L6029 | Transcarpal/metacarpal or partial hand disarticulation prosthesis, external power, self-suspended, inner socket with removable forearm section, electrodes and cables, two batteries, charger, myoelectric control of terminal device, excludes terminal device(s) | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L6050 | Wrist disarticulation, molded socket, flexible elbow hinges, triceps pad | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L6055 | Wrist disarticulation, molded socket with expandable interface, flexible elbow hinges, triceps pad | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L6100 | Below elbow, molded socket, flexible elbow hinge, triceps pad | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L6110 | Below elbow, molded socket, (muenster or northwestern suspension types) | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L6120 | Below elbow, molded double wall split socket, step-up hinges, half cuff | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L6130 | Below elbow, molded double wall split socket, stump activated locking hinge, half cuff | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L6200 | Elbow disarticulation, molded socket, outside locking hinge, forearm | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L6205 | Elbow disarticulation, molded socket with expandable interface, outside locking hinges, forearm | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L6250 | Above elbow, molded double wall socket, internal locking elbow, forearm | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |

| CPT and HCPCS Codes That May Require Prior Authorization | Description of Procedure Code | Medical Records Request Information Required |
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| L6300 | Shoulder disarticulation, molded socket, shoulder bulkhead, humeral section, internal locking elbow, forearm | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L6310 | Shoulder disarticulation, passive restoration (complete prosthesis) | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L6320 | Shoulder disarticulation, passive restoration (shoulder cap only) | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L6350 | Interscapular thoracic, molded socket, shoulder bulkhead, humeral section, internal locking elbow, forearm | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L6360 | Interscapular thoracic, passive restoration (complete prosthesis) | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L6370 | Interscapular thoracic, passive restoration (shoulder cap only) | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L6380 | Immediate postsurgical or early fitting, application of initial rigid dressing, including fitting alignment and suspension of components, and one cast change, wrist disarticulation or below elbow | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L6382 | Immediate postsurgical or early fitting, application of initial rigid dressing including fitting alignment and suspension of components, and one cast change, elbow disarticulation or above elbow | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L6384 | Immediate postsurgical or early fitting, application of initial rigid dressing including fitting alignment and suspension of components, and one cast change, shoulder disarticulation or interscapular thoracic | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L6400 | Below elbow, molded socket, endoskeletal system, including soft prosthetic tissue shaping | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L6450 | Elbow disarticulation, molded socket, endoskeletal system, including soft prosthetic tissue shaping | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |

| CPT and HCPCS Codes That May Require Prior Authorization | Description of Procedure Code | Medical Records Request Information Required |
|--|---|--|
| L6500 | Above elbow, molded socket, endoskeletal system, including soft prosthetic tissue shaping | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L6550 | Shoulder disarticulation, molded socket, endoskeletal system, including soft prosthetic tissue shaping | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L6570 | Interscapular thoracic, molded socket, endoskeletal system, including soft prosthetic tissue shaping | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L6580 | Preparatory, wrist disarticulation or below elbow, single wall plastic socket, friction wrist, flexible elbow hinges, figure of eight harness, humeral cuff, Bowden cable control, USMC or equal pylon, no cover, molded to patient model | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L6582 | Preparatory, wrist disarticulation or below elbow, single wall socket, friction wrist, flexible elbow hinges, figure of eight harness, humeral cuff, Bowden cable control, USMC or equal pylon, no cover, direct formed | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L6584 | Preparatory, elbow disarticulation or above elbow, single wall plastic socket, friction wrist, locking elbow, figure of eight harness, fair lead cable control, USMC or equal pylon, no cover, molded to patient model | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L6586 | Preparatory, elbow disarticulation or above elbow, single wall socket, friction wrist, locking elbow, figure of eight harness, fair lead cable control, USMC or equal pylon, no cover, direct formed | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L6588 | Preparatory, shoulder disarticulation or interscapular thoracic, single wall plastic socket, shoulder joint, locking elbow, friction wrist, chest strap, fair lead cable control, usmc or equal pylon, no cover, molded to patient model | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |

| CPT and HCPCS Codes That May Require Prior Authorization | Description of Procedure Code | Medical Records Request Information Required |
|--|---|--|
| L6590 | Preparatory, shoulder disarticulation or interscapular thoracic, single wall socket, shoulder joint, locking elbow, friction wrist, chest strap, fair lead cable control, USMC or equal pylon, no cover, direct formed | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L6624 | Upper extremity addition, flexion/extension and rotation wrist unit | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L6638 | Upper extremity addition to prosthesis, electric locking feature, only for use with manually powered elbow | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L6646 | Upper extremity addition, shoulder joint, multipositional locking, flexion, adjustable abduction friction control, for use with body powered or external powered system | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L6648 | Upper extremity addition, shoulder lock mechanism, external powered actuator | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L6693 | Upper extremity addition, locking elbow, forearm counterbalance | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L6696 | Addition to upper extremity prosthesis, below elbow/above elbow, custom fabricated socket insert for congenital or atypical traumatic amputee, silicone gel, elastomeric or equal, for use with or without locking mechanism, initial only (for other than initial, use code L6694 or L6695) | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L6697 | Addition to upper extremity prosthesis, below elbow/above elbow, custom fabricated socket insert for other than congenital or atypical traumatic amputee, silicone gel, elastomeric or equal, for use with or without locking mechanism, initial only (for other than initial, use code L6694 or L6695) | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L6707 | Terminal device, hook, mechanical, voluntary closing, any material, any size, lined or unlined | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |

| CPT and HCPCS Codes That May Require Prior Authorization | Description of Procedure Code | Medical Records Request Information Required |
|--|---|--|
| L6709 | Terminal device, hand, mechanical, voluntary closing, any material, any size | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L6712 | Terminal device, hook, mechanical, voluntary closing, any material, any size, lined or unlined, pediatric | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L6713 | Terminal device, hand, mechanical, voluntary opening, any material, any size, pediatric | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L6714 | Terminal device, hand, mechanical, voluntary closing, any material, any size, pediatric | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L6715 | Terminal device, multiple articulating digit, includes motor(s), initial issue or replacement | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L6721 | Terminal device, hook or hand, heavy duty, mechanical, voluntary opening, any material, any size, lined or unlined | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L6722 | Terminal device, hook or hand, heavy-duty, mechanical, voluntary closing, any material, any size, lined or unlined | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L6880 | Electric hand, switch or myoelectric controlled, independently articulating digits, any grasp pattern or combination of grasp patterns, includes motor(s) | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L6881 | Automatic grasp feature, addition to upper limb electric prosthetic terminal device | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L6882 | Microprocessor control feature, addition to upper limb prosthetic terminal device | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L6883 | Replacement socket, below elbow/wrist disarticulation, molded to patient model, for use with or without external power | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L6884 | Replacement socket, above elbow/elbow disarticulation, molded to patient model, for use with or without external power | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L6885 | Replacement socket, shoulder disarticulation/interscapular thoracic, molded to patient model, for use with or without external power | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |

| CPT and HCPCS Codes That May Require Prior Authorization | Description of Procedure Code | Medical Records Request Information Required |
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| L6900 | Hand restoration (casts, shading and measurements included), partial hand, with glove, thumb or one finger remaining | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L6905 | Hand restoration (casts, shading and measurements included), partial hand, with glove, multiple fingers remaining | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L6910 | Hand restoration (casts, shading and measurements included), partial hand, with glove, no fingers remaining | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L6920 | Wrist disarticulation, external power, self-suspended inner socket, removable forearm shell, otto bock or equal, switch, cables, two batteries and one charger, switch control of terminal device | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L6925 | Wrist disarticulation, external power, self-suspended inner socket, removable forearm shell, otto bock or equal electrodes, cables, two batteries and one charger, myoelectronic control of terminal device | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L6930 | Below elbow, external power, self-suspended inner socket, removable forearm shell, Otto Bock or equal switch, cables, 2 batteries and one charger, switch control of terminal device | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L6935 | Below elbow, external power, self-suspended inner socket, removable forearm shell, otto bock or equal electrodes, cables, two batteries and one charger, myoelectronic control of terminal device | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L6940 | Elbow disarticulation, external power, molded inner socket, removable humeral shell, outside locking hinges, forearm, Otto Bock or equal switch, cables, 2 batteries and one charger, switch control of terminal device | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L6945 | Elbow disarticulation, external power, molded inner socket, removable humeral shell, outside locking hinges, forearm, otto bock or equal electrodes, cables, two batteries and one charger, myoelectronic control of terminal device | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |

| CPT and HCPCS Codes That May Require Prior Authorization | Description of Procedure Code | Medical Records Request Information Required |
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| L6950 | Above elbow, external power, molded inner socket, removable humeral shell, internal locking elbow, forearm, otto bock or equal switch, cables, two batteries and one charger, switch control of terminal device | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L6955 | Above elbow, external power, molded inner socket, removable humeral shell, internal locking elbow, forearm, otto bock or equal electrodes, cables, two batteries and one charger, myoelectronic control of terminal device | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L6960 | Shoulder disarticulation, external power, molded inner socket, removable shoulder shell, shoulder bulkhead, humeral section, mechanical elbow, forearm, otto bock or equal switch, cables, two batteries and one charger, switch control of terminal device | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L6965 | Shoulder disarticulation, external power, molded inner socket, removable shoulder shell, shoulder bulkhead, humeral section, mechanical elbow, forearm, otto bock or equal electrodes, cables, two batteries and one charger, myoelectronic control of terminal device | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L6970 | Interscapular-thoracic, external power, molded inner socket, removable shoulder shell, shoulder bulkhead, humeral section, mechanical elbow, forearm, otto bock or equal switch, cables, two batteries and one charger, switch control of terminal device | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L6975 | Interscapular-thoracic, external power, molded inner socket, removable shoulder shell, shoulder bulkhead, humeral section, mechanical elbow, forearm, otto bock or equal electrodes, cables, two batteries and one charger, myoelectronic control of terminal device | Letter of Medical Necessity including length of time equipment needed, functional status if applicable and description of medical condition. |
| L7007 | ELECTRIC HAND, SWITCH OR MYOELECTRIC CONTROLLED, ADULT | History and physical, letter of medical necessity and functional status eval from psychiatrist or physical therapist. |

| CPT and HCPCS Codes That May Require Prior Authorization | Description of Procedure Code | Medical Records Request Information Required |
|--|--|--|
| L7008 | Electric hand, switch or myoelectric, controlled, pediatric | History and physical, letter of medical necessity and functional status eval from physiatrist or physical therapist. |
| L7009 | Electric hook, switch or myoelectric controlled, adult | History and physical, letter of medical necessity and functional status eval from physiatrist or physical therapist. |
| L7040 | Prehensile actuator, switch controlled | History and physical, letter of medical necessity and functional status eval from physiatrist or physical therapist. |
| L7045 | Electric hook, switch or myoelectric controlled, pediatric | History and physical, letter of medical necessity and functional status eval from physiatrist or physical therapist. |
| L7170 | Electronic elbow, hosmer or equal, switch controlled | History and physical, letter of medical necessity and functional status eval from physiatrist or physical therapist. |
| L7180 | Electronic elbow, microprocessor sequential control of elbow and terminal device | History and physical, letter of medical necessity and functional status eval from physiatrist or physical therapist. |
| L7181 | Electronic elbow, microprocessor simultaneous control of elbow and terminal device | History and physical, letter of medical necessity and functional status eval from physiatrist or physical therapist. |
| L7185 | Electronic elbow, adolescent, variety village or equal, switch controlled | History and physical, letter of medical necessity and functional status eval from physiatrist or physical therapist. |
| L7186 | Electronic elbow, child, variety village or equal, switch controlled | History and physical, letter of medical necessity and functional status eval from physiatrist or physical therapist. |
| L7190 | Electronic elbow, adolescent, variety village or equal, myoelectronically controlled | History and physical, letter of medical necessity and functional status eval from physiatrist or physical therapist. |
| L7191 | Electronic elbow, child, variety village or equal, myoelectronically controlled | History and physical, letter of medical necessity and functional status eval from physiatrist or physical therapist. |
| L7259 | Electronic wrist rotator, any type | History and physical, letter of medical necessity and functional status eval from physiatrist or physical therapist. |
| L8040 | Nasal prosthesis, provided by a nonphysician | History and physical, letter of medical necessity and functional status eval from physiatrist or physical therapist. |
| L8041 | Midfacial prosthesis, provided by a nonphysician | History and physical, letter of medical necessity and functional status eval from physiatrist or physical therapist. |
| L8042 | Orbital prosthesis, provided by a non-physician | Letter of medical necessity, including condition being treated. |

| CPT and HCPCS Codes That May Require Prior Authorization | Description of Procedure Code | Medical Records Request Information Required |
|--|--|--|
| L8043 | Upper facial prosthesis, provided by a non-physician | Letter of medical necessity, including condition being treated. |
| L8044 | Hemi-facial prosthesis, provided by a non-physician | Letter of medical necessity, including condition being treated. |
| L8045 | Auricular prosthesis, provided by a non-physician | Letter of medical necessity, including condition being treated. |
| L8046 | Partial facial prosthesis, provided by a nonphysician | Letter of medical necessity, including condition being treated. |
| L8047 | Nasal septal prosthesis, provided by a nonphysician | Letter of medical necessity, including condition being treated. |
| L8609 | Artificial cornea | Letter of medical necessity, including condition being treated. |
| L8614 | COCHLEAR DEVICE, INCLUDES ALL INTERNAL AND EXTERNAL COMPONENTS | Pre-operative Evaluation, operative report, previous use of hearing aids, level of hearing Impairment. |
| L8619 | COCHLEAR IMPLANT, EXTERNAL SPEECH PROCESSOR AND CONTROLLER, INTEGRATED SYSTEM, REPLACEMENT | Pre-operative Evaluation, operative report, previous use of hearing aids, level of hearing Impairment. |
| L8627 | Cochlear implant, external speech processor, component, replacement | Letter of medical necessity, including condition being treated. |
| L8628 | Cochlear implant, external controller component, replacement | Letter of medical necessity, including condition being treated. |
| L8629 | Transmitting coil and cable, integrated, for use with cochlear implant device, replacement | Letter of medical necessity, including condition being treated. |
| L8631 | Metacarpal phalangeal joint replacement, 2 or more pieces, metal (e.g., stainless steel or cobalt chrome), ceramic-like material (e.g., pyrocarbon), for surgical implantation (all sizes, includes entire system) | Letter of medical necessity, including condition being treated. |
| L8659 | Interphalangeal finger joint replacement, 2 or more pieces, metal (e.g., stainless steel or cobalt chrome), ceramic-like material (e.g., pyrocarbon) for surgical implantation, any size | Letter of medical necessity, including condition being treated. |
| L8679 | Implantable neurostimulator, pulse generator, any type | Letter of medical necessity, including condition being treated. |
| L8681 | Patient programmer (external) for use with implantable programmable neurostimulator pulse generator, replacement only | Recent history and physical, plan of care, and documentation of medical necessity. |
| L8682 | Implantable neurostimulator radiofrequency receiver | Recent history and physical, plan of care, and documentation of medical necessity. |

| CPT and HCPCS Codes That May Require Prior Authorization | Description of Procedure Code | Medical Records Request Information Required |
|--|--|---|
| L8683 | Radiofrequency transmitter (external) for use with implantable neurostimulator radiofrequency receiver | Recent history and physical, plan of care, and documentation of medical necessity. |
| L8684 | Radiofrequency transmitter (external) for use with implantable sacral root neurostimulator receiver for bowel and bladder management, replacement | Recent history and physical, plan of care, and documentation of medical necessity. |
| L8685 | Implantable neurostimulator pulse generator, single array, rechargeable, includes extension | Recent history and physical, plan of care, and documentation of medical necessity. |
| L8686 | Implantable neurostimulator pulse generator, single array, nonrechargeable, includes extension | Recent history and physical, plan of care, and documentation of medical necessity. |
| L8687 | Implantable neurostimulator pulse generator, dual array, rechargeable, includes extension | Recent history and physical, plan of care, and documentation of medical necessity. |
| L8688 | Implantable neurostimulator pulse generator, dual array, nonrechargeable, includes extension | Recent history and physical, plan of care, and documentation of medical necessity. |
| L8689 | External recharging system for battery (internal) for use with implantable neurostimulator, replacement only | Recent history and physical, plan of care, and documentation of medical necessity. |
| L8690 | Auditory osseointegrated device, includes all internal and external components | Recent history and physical, plan of care, and documentation of medical necessity. |
| L8691 | Auditory osseointegrated device, external sound processor, replacement | Recent history and physical, plan of care, and documentation of medical necessity. |
| L8692 | Auditory osseointegrated device, external sound processor, used without osseointegration, body worn, includes headband or other means of external attachment | Recent history and physical, plan of care, and documentation of medical necessity. |
| M0076 | Prolotherapy | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| Q0479 | Power module for use with electric or electric/pneumatic ventricular assist device, replacement only | Recent history and physical, plan of care, and documentation of medical necessity. |
| Q0480 | Driver for use with pneumatic ventricular assist device, replacement only | Recent history and physical, plan of care, and documentation of medical necessity. |
| Q0481 | Microprocessor control unit for use with electric ventricular assist device, replacement only | Recent history and physical, plan of care, and documentation of medical necessity. |

| CPT and HCPCS Codes That May Require Prior Authorization | Description of Procedure Code | Medical Records Request Information Required |
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| Q0482 | Microprocessor control unit for use with electric/pneumatic combination ventricular assist device, replacement only | Recent history and physical, plan of care, and documentation of medical necessity. |
| Q0483 | Monitor/display module for use with electric ventricular assist device, replacement only | Recent history and physical, plan of care, and documentation of medical necessity. |
| Q0484 | Monitor/display module for use with electric or electric/pneumatic ventricular assist device, replacement only | Recent history and physical, plan of care, and documentation of medical necessity. |
| Q0489 | Power pack base for use with electric/pneumatic ventricular assist device, replacement only | Recent history and physical, plan of care, and documentation of medical necessity. |
| Q0495 | Battery/power pack charger for use with electric or electric/pneumatic ventricular assist device, replacement only | Recent history and physical, plan of care, and documentation of medical necessity. |
| Q2017 | Injection, teniposide, 50 mg | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| Q2043 | Sipuleucel-t, minimum of 50 million autologous cd54+ cells activated with pap-gm-csf, including leukapheresis and all other preparatory procedures, per infusion | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| Q2050 | Injection, doxorubicin hydrochloride, liposomal, not otherwise specified, 10 mg | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| Q4131 | Epifix, per square centimeter (Human amniotic membrane allograft) | Recent history and physical, plan of care, and documentation of medical necessity. |
| Q4132 | Grafix core, per square centimeter | Recent history and physical, plan of care, and documentation of medical necessity. |
| Q4133 | Grafix prime, per square centimeter | Recent history and physical, plan of care, and documentation of medical necessity. |
| Q5101 | Injection, filgrastim (g-csf), biosimilar, 1 microgram | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| Q5103 | Q5103 Injection, infliximab-dyyb, biosimilar, 10 mg. New code effective 4/1/18 previously coded Q5102 which was deleted 3/31/18 Went live 11/1/17 | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| Q5104 | 100 MG SOLR Q5104 Injection, infliximab-abda, biosimilar, 10 mg. New code effective 4/1/18 previously coded J3590, Go live 11/1/17 | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| Q5106 | epoetin alfa, biosimilar, (Retacrit) (for non-esrd use), 1000 units | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |

| CPT and HCPCS Codes That May Require Prior Authorization | Description of Procedure Code | Medical Records Request Information Required |
|--|--|---|
| Q5107 | Bevacizumab-awwb | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| Q5108 | Injection, pegfilgrastim-jmdb, biosimilar, (fulphila), 0.5 mg | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| Q5110 | Injection, filgrastim-aafi, biosimilar, (Nivestym), 1 microgram | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| Q5111 | Pegfilgrastim-cbqv | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| Q5112 | Trastuzumab-dttb | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| Q5113 | Trastuzumab-pkrb | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| Q5114 | Trastuzumab-dkst | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| Q5115 | Rituximab-abbs | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| Q5116 | Trastuzumab-qyyp | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| Q5117 | Trastuzumab-anns | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| Q5118 | Bevacizumab-bvzr | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| Q5119 | Rituximab-pvvr OR Ruxience | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| Q5119 | Rituximab-pvvr | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| Q5120 | Pegfilgrastim-bmez OR Ziextenzo | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| Q5121 | Injection; Immunomodulators | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| Q5122 | Nyvepria | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| S0013 | Spravato | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| S0145 | Injection, pegylated interferon alfa-2a, 180 mcg per ml | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| S0148 | Injection, pegylated interferon alfa-2b, 10 mcg | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| S2095 | Transcatheter occlusion or embolization for tumor destruction, percutaneous, any method, using yttrium-90 microspheres | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |

| CPT and HCPCS Codes That May Require Prior Authorization | Description of Procedure Code | Medical Records Request Information Required |
|--|--|---|
| S2118 | Metal-on-metal total hip resurfacing, including acetabular and femoral components | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| S3800 | Genetic testing for amyotrophic lateral sclerosis (als) | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| S3840 | DNA analysis for germline mutations of the ret proto-oncogene for susceptibility to multiple endocrine neoplasia type 2 | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| S3841 | Genetic testing for retinoblastoma | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| S3842 | Genetic testing for von hippel-lindau disease | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| S3844 | DNA analysis of the connexin 26 gene (gjb2) for susceptibility to congenital, profound deafness | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| S3845 | Genetic testing for alpha-thalassemia | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| S3846 | Genetic testing for hemoglobin e beta-thalassemia | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| S3850 | Genetic testing for sickle cell anemia | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| S3852 | DNA analysis for apoe epsilon 4 allele for susceptibility to alzheimer's disease | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| S3854 | Gene expression profiling panel for use in the management of breast cancer treatment | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| S3861 | Genetic testing, sodium channel, voltage-gated, type v, alpha subunit (scn5a) and variants for suspected brugada syndrome | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| S3865 | Comprehensive gene sequence analysis for hypertrophic cardiomyopathy | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| S3866 | Genetic analysis for a specific gene mutation for hypertrophic cardiomyopathy (hcm) in an individual with a known hcm mutation in the family | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| S3870 | Comparative genomic hybridization (cgh) microarray testing for developmental delay, autism spectrum disorder and/or intellectual disability | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| S5100 | Adult Day Service LTSS | 15 minutes = 1 unit |
| S5125 | *Personal Care Assistant LTSS | 15 minutes = 1 unit |

| CPT and HCPCS Codes That May Require Prior Authorization | Description of Procedure Code | Medical Records Request Information Required |
|--|--|--|
| S5126 | *Personal Care Assistant LTSS | 15 minutes = 1 unit |
| S5130 | Homemaker/Housekeeper Services LTSS | 15 minutes = 1 unit |
| S5160 | Electronic Home Response - Installation | 1/Lifetime |
| S5161 | Electronic Home Response - Monthly Rent | 1/Month |
| S5165 | Environmental Accessibility Adaptations - Home LTSS | Services are limited to service cost/plan maximum according to member's need. Services limited to \$25,000 within a 5 year period. |
| S5170 | Home Delivered Meals LTSS | 2 meals per day and up to 7 days a week (2 meals = 1 unit; Time Period = month) |
| S5501 | Home infusion therapy, catheter care / maintenance, complex (more than one lumen), includes administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem | Recent history and physical, plan of care, and documentation of medical necessity. |
| S8037 | Magnetic resonance cholangiopancreatography (mrCP) | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| S8042 | Magnetic resonance imaging (mri), low-field | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| S8085 | Fluorine-18 fluorodeoxyglucose (F-18 fdg) imaging using dual-head coincidence detection system (non-dedicated PET scan) | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| S8092 | Electron beam computed tomography (also known as ultrafast ct, cine ct) | eviCore - 1-855-252-1117 or https://www.evicore.com/healthplan/bcbs |
| S9123 | Nursing care in the home, by RN, per hour (use for general nursing care only, not to be used when cpt codes 99500-99602 can be used). | Recent history and physical, plan of care, and documentation of medical necessity. |
| S9341 | Home therapy; enteral nutrition via gravity; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (enteral formula and nursing visits coded separately), per diem | Recent history and physical, plan of care, and documentation of medical necessity. |

| CPT and HCPCS Codes That May Require Prior Authorization | Description of Procedure Code | Medical Records Request Information Required |
|--|---|--|
| S9342 | Home therapy; enteral nutrition via pump; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (enteral formula and nursing visits coded separately), per diem | Recent history and physical, plan of care, and documentation of medical necessity. |
| S9343 | Home therapy; enteral nutrition via bolus; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (enteral formula and nursing visits coded separately), per diem | Recent history and physical, plan of care, and documentation of medical necessity. |
| S9366 | Home infusion therapy, total parenteral nutrition (tpn); more than one liter but no more than two liters per day, administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment including standard tpn formula (lipids, specialty amino acid formulas, drugs other than in standard formula and nursing visits coded separately), per diem | Recent history and physical, plan of care, and documentation of medical necessity. |
| S9494 | Home infusion therapy, antibiotic, antiviral, or antifungal therapy; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem (do not use this code with home infusion codes for hourly dosing schedules s9497-s9504) | Recent history and physical, plan of care, and documentation of medical necessity. |
| S9501 | Home infusion therapy, antibiotic, antiviral, or antifungal therapy; once every 12 hours; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem | Recent history and physical, plan of care, and documentation of medical necessity. |
| T1005 | Respite - Homemaker LTSS | 15 minutes = 1 unit |
| T1005* | Respite - Personal Assistant LTSS | Available for waivers except Elderly. |
| T1019 | *Personal Care Assistant LTSS | 15 minutes = 1 unit |

| CPT and HCPCS Codes That May Require Prior Authorization | Description of Procedure Code | Medical Records Request Information Required |
|--|---|--|
| T1020 | *Personal Care Assistant LTSS | 15 minutes = 1 unit |
| T2003 | Adult Day Service Transportation LTSS | Max of 2 visits per day. 1 way=1unit |
| T2014 | Pre-vocational Services LTSS | Brain injury waiver only. Per diam |
| T2019 | Supported Employment LTSS | Brain injury waiver only. |
| T2020 | Habitation - Day LTSS | Brain injury waiver only. |
| T2101 | Human Breast Milk | Recent history and physical, plan of care, and documentation of medical necessity. |
| V5011 | Fitting/orientation/checking of hearing aid | Letter of medical necessity, including condition being treated. |
| V5014 | Repair/modification of a hearing aid | Letter of medical necessity, including condition being treated. |
| V5090 | Dispensing fee, unspecified hearing aid | Letter of medical necessity, including condition being treated. |
| V5095 | SEMI-IMPLANTABLE MIDDLE EAR HEARING PROSTHESIS | History and physical, operative report. |
| V5273 | Assistive listening device, for use with cochlear implant | Letter of medical necessity, including condition being treated. |
| V5275 | Ear impression, each | Letter of medical necessity, including condition being treated. |
| V5281 | Assistive listening device, personal fm/dm system, monaural, (1 receiver, transmitter, microphone), any type | Letter of medical necessity, including condition being treated. |
| V5282 | Assistive listening device, personal fm/dm system, binaural, (2 receivers, transmitter, microphone), any type | Letter of medical necessity, including condition being treated. |
| V5283 | Assistive listening device, personal fm/dm neck, loop induction receiver | Letter of medical necessity, including condition being treated. |
| V5284 | Assistive listening device, personal fm/dm, ear level receiver | Letter of medical necessity, including condition being treated. |
| V5285 | Assistive listening device, personal fm/dm, direct audio input receiver | Letter of medical necessity, including condition being treated. |
| V5286 | Assistive listening device, personal blue tooth fm/dm receiver | Letter of medical necessity, including condition being treated. |
| V5287 | Assistive listening device, personal fm/dm receiver, not otherwise specified | Letter of medical necessity, including condition being treated. |
| V5288 | Assistive listening device, personal fm/dm transmitter assistive listening device | Letter of medical necessity, including condition being treated. |
| V5289 | Assistive listening device, personal fm/dm adapter/boot coupling device for receiver, any type | Letter of medical necessity, including condition being treated. |
| V5298 | Hearing aid, not otherwise classified | Letter of medical necessity, including condition being treated. |

| CPT and HCPCS Codes That May Require Prior Authorization | Description of Procedure Code | Medical Records Request Information Required |
|--|---|--|
| V5299 | Hearing service, miscellaneous | Letter of medical necessity, including condition being treated. |
| Behavioral Health | | |
| H2036 | Substance Abuse Adolescent Residential | For Service Request, please contact customer service representative |
| H0047 | Substance Abuse Rehabilitation | For Service Request, please contact customer service representative |
| H0010 | Substance Acute Abuse Detoxification | For Service Request, please contact customer service representative |
| H0004 TF | SUPR Intensive Outpatient Service - Individual | For Service Request, please contact customer service representative |
| H0005 TF | SUPR Intensive Outpatient Services - Group | For Service Request, please contact customer service representative |
| H0002 | Behavioral Health screening to determine eligibility for admission to treatment program | For Service Request beyond 8 units (1 unit = 15 min), please contact customer service representative PA required only beyond 8 units |
| H0004 | BH: Alcohol and/or substance abuse services, group counseling by a clinician | For Service Request beyond 12 units (1 unit = 15 min) please contact customer service representative Prior auth required only beyond 12 units |
| H0005 | Alcohol and/or substance abuse services, group counseling by a clinician | For Service Request beyond 12 units (1 unit = 15 min) please contact customer service representative Prior Auth required only beyond 12 units |
| S9480 | Mental Health Intensive Outpatient Services | For Service Request, please contact customer service representative |
| H0039 | Assertive Community Treatment | For Illinois Medicaid Service Request, please complete and submit Rule 132 Authorization Form. https://www.bcbsil.com/provider/education/forms.html 1 unit=15 min |
| H2016 | Community Support Team | For Illinois Medicaid Service Request, please complete and submit Rule 132 Authorization Form. https://www.bcbsil.com/provider/education/forms.html 1 unit=15 min |

| CPT and HCPCS Codes That May Require Prior Authorization | Description of Procedure Code | Medical Records Request Information Required |
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| H2017 | Psychosocial Rehabilitation | For Illinois Medicaid Service Request, please complete and submit Rule 132 Authorization Form. https://www.bcbsil.com/provider/education/forms.html 1 unit = 15 min |
| 90870 | Electroconvulsive Therapy | For Service Request, please contact customer service representative |
| 90867 | Transcranial Magnetic Stimulation | For Service Request, please contact customer service representative |
| 90867 | Transcranial Magnetic Stimulation | For Service Request, please contact customer service representative |
| 90868 | Transcranial Magnetic Stimulation | For Behavioral Health primary dx Service Request, please contact customer service representative |
| 97151 | Behavior Identification Assessment | For Behavioral Health primary dx Service Request, please contact customer service representative |
| 97152 | Behavior Identification Supporting Assessment | For Behavioral Health primary dx Service Request, please contact customer service representative |
| 97153 | Adaptive Behavior Treatment by Protocol | For Behavioral Health primary dx Service Request, please contact customer service representative |
| 97154 | Group Adaptive Behavior Treatment by Protocol | For Behavioral Health primary dx Service Request, please contact customer service representative |
| 97155 | Adaptive Behavior Treatment with Protocol Modification | For Behavioral Health primary dx Service Request, please contact customer service representative |
| 97156 | Family Adaptive Behavior Treatment Guidance | For Behavioral Health primary dx Service Request, please contact customer service representative |
| 97157 | Multiple Family Group Adaptive Behavior Treatment Guidance | For Behavioral Health primary dx Service Request, please contact customer service representative |
| 97158 | Group Adaptive Behavior Treatment with Protocol Modification | For Behavioral Health primary dx Service Request, please contact customer service representative |
| 0362T | Behavior Identification Supporting Assessment | For Behavioral Health primary dx Service Request, please contact customer service representative |
| 0373T | Adaptive Behavior Treatment with Protocol Modification | For Behavioral Health primary dx Service Request, please contact customer service representative |

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Checking eligibility and/or benefit information and/or the fact that a service has been prior authorized is not a guarantee of payment. Benefits will be determined once a claim is received and will be based upon, among other things, the member's eligibility and the terms of the member's certificate of coverage applicable on the date services were rendered. If you have questions, contact the appropriate number on the member's ID card.

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| CPT and HCPCS Codes That May Require Prior Authorization | Description of Procedure Code | Medical Records Request Information Required |
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